DOCUMENT RESUME

ED 387 745 CG 026 525

AUTHOR	Mutchler, Sue E.; And Others
TITLE	Finding Common Ground: Creating Local Governance Structures.
INSTITUTION	Southwest Educational Development Lab., Austin, Tex.
SPONS AGENCY	Office of Educational Research and Improvement (ED), Washington, DC.
PUB DATE	93
CONTRACT	RP91002003
NOTE	173p.
PUB TYPE	Books (010) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Adolescents; *Child Advocacy; Child Health; *Childhood Needs; Children; Childrens Rights; Child Welfare; Elementary Secondary Education; Family Problems; *Family Programs; Governance; Helping Relationship; *Integrated Services; Policy Analysis; Public Agencies; *Public Policy; State Government; State Programs

ABSTRACT

As federal, state, and local policy makers attend to the economic, educational, social, and health-related needs of children, they are beginning to share a vision of a "seamless web" of high-quality, comprehensive, continuous services for children and their families. It remains a challenging goal because of the complexity of children's needs and the variety of organizations, procedures, structures, and systems set in place to address those needs. This Occasional Paper focuses on the ways in which many states and localities are creating new service systems and roles through a variety of local governance structures. The following eight profiles describe a range of different interventions: (1) Arkansas, Arkansas Families First; (2) California, Healthy Start (Senate Bill 620); (3) Colorado, Family and Children's Initiative; (4) Florida, District Health and Human Services Boards; (5) Iowa, Family Development and Self-Sufficiency Program; (6) Kentucky, Family Resource Centers and Youth Services Centers; (7) Maryland, Children and Family Services Reform Initiative; and (8) New Mexico, Communities in Schools. All eight initiatives emphasize the role of collaboration in creating new possibilities, roles, and relationships for local communities. Each profile is a synthesis of information collection from one or more informants in the state, representing a landscape for analysis and comparison. (JBJ)

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Finding Common Ground:

Creating Local Governance Structures

by

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Introduction

As federal, state, and local policymakers attend to the economic, educational, social, and health-related needs of children, they are beginning to share a vision of a "seamless web" of high-quality, comprehensive, continuous services for children *and* their families.

Finding Common Ground

Taking action to weave such a web is a reasonable goal, for if a child's emotional and physical needs are not addressed, they can have a direct and negative affect on his or her progress in school or the family's well-being in its community. It remains a challenging goal because of the complexity of children's needs and the variety of organizations, procedures, structures, and systems set in place to address those needs. Speaking of the problems facing poor children, Richard Weissbourd (1991) describes a new vision and action plan for those who seek to serve children in need:

> These problems—shaped by complex social and economic forces—are not, to be sure, the problems of the service system alone. They are the problems of many systems—the employment "system," for example, the income maintenance system, the housing system—and they implicate nearly every agency of government. And while they are national problems demanding national solutions, they **are also the problems of individual communities and citizens** [emphasis added]. They will not, therefore, be driven away by service strategies or even by broad public policies in isolation. They will be uprooted through a range of different and concerted **public and private** [emphasis added] interventions. (p. 3)

Policymakers and service providers can wade to common ground out of the swamp of individual expectations, myriad local programs, and fragmented federal and state service delivery efforts—if they come together with individuals to accept their mutual responsibility for the way they do business. And, if they are willing to **change** the way they do business.

Weissbourd's observation implies a change in the way federal and state governments interact with localities. Certainly, federal and state governments play a role in meeting the needs of local citizens and they will continue to do so. But if complex problems are to be addressed in any lasting way, the role needs to change from one based on patronage to one of mutual advantage. The literature reviewed for this paper suggests that federal and state governments must enable localities to determine, govern, and maintain accountability for service systems that meet the needs of their people.

Creating Local Governance Structures

Many states and localities (e.g., cities, towns, or counties) are beginning to create new service systems and roles through a variety of **local governance structures**. The concepts of governance and local governance structures are central themes of this Occasional Paper. Whether they are called local policy councils, advisory councils, or district health and human services boards—local governance structures have the authority and autonomy to allocate resources, deliver services, and maintain accountability. The process of developing local governance structures is politically and technically challenging, says the Council for the Study of Social Policy (CSSP). "Politically it changes the roles of all involved while technically the new form of governance must be designed to fit with and complement existing governmental authorities and agencies" (CSSP, 1991, p. 2).

Policymakers and service providers can wade to common ground out of the swamp of individual expectations, myriad local programs, and fragmented federal and state service delivery efforts.

The eight profiles in this Occasional Paper describe what Weissbourd (1991, p. 3) called "a range of different and concerted public and private interventions," created by the states of Arkansas, California, Colorado, Florida, Iowa, Kentucky, Maryland, and New Mexico. With some of their localities, these states are investing resources and high expectations in the development of various forms of local governance structures that can help streamline, coordinate, and ultimately improve health and social services for children and their families.

Some of these states have only three or four sites, while others have hundreds. Some provide permanent sources of funding; others assure only first-year seed money. Some require direct linkage with the local school or district, and some leave such connections to local discretion. All, however, appear to have as their central purpose the nurturing of community responsibility, ownership, and authority to meet the health and social service needs of children and their families. "The goal," said a staff

member in Florida's Office of the Governor, "is **system change**, not just **service delivery improvement**. The bottom-line goal is to create a system that translates into meaningful, helpful, consistent service to the people who need help who walk in our doors."

All eight initiatives emphasize the role of collaboration in creating new possibilities, roles, and relationships for local communities. "[Local policy team members] don't quite believe that the ability to really change the system is in their hands," observed a staff member of the Arkansas Family Policy Council. "By connecting the viability and the health of these families to the viability and health of the communities, we have been able to bring in some new players—[particularly] mayors and city managers."

Eight Initiatives

This Occasional Paper profiles the following eight initiatives. Each profile is a synthesis of information collected from one or more informants in the state. Together, they represent a landscape for analysis and comparison of various ways in which states are initiating, designing, and supporting local governance structures. Future papers in this series will examine specific features of local governance structures. They also will identify some commonalities that might offer insights to policymakers who are seeking ways to improve the delivery of education and other services in their states and localities.

Arkansas Families First is a comprehensive program of family support initiated by the Family Policy Council of the Office of the Governor in the late 1980s. The legislature provided direction and appropriations in a 1992 special session (Act 1), enabling thirteen communities to receive one-year funding to establish local Families First initiatives; additional funds have been appropriated for the next biennium. Each locality created a family policy team and hired a community coordinator to develop and direct local efforts to serve families at risk. Teams are, at a minimum, comprised of local representatives from the Departments of Health and Human Services, JTPA, and the school district. The intention is for policy teams to influence how state services are delivered, by requesting waivers and providing input to the state-level Policy Council, as well as to develop and facilitate the provision of new local services by coordinating community resources.

California's **Healthy Start (Senate Bill 620)** became effective January 1, 1992. The initiative has as its overall objective the provision of more flexibility in the delivery of services to children and families in the state, with a particular focus on prevention. To accomplish this, the initiative takes a school-based approach to coordinating services for low-income and limited English proficient children and their families. Local collaboratives are comprised of public and private agency representatives, parents, and teachers. School districts, county offices of education, and consortia are eligible for planning and/or operational grants (up to three years maximum). As of early 1993, there are 65 operational sites, and over 100 sites are recipients of planning grants. It is intended that local collaboration and flexibility in blending funding streams not only will improve service delivery in the community but also lead to change in how the state uses funds for health and human services and how agencies collaborate at the state level.

The **Family and Children's Initiative** in Colorado emerged from a comprehensive strategic plan developed through the Office of the Governor. The plan includes the development of community-based Family Centers as a way to pilot a number of system changes that will support, strengthen, and promote successful family functioning in all areas, from health to education to employment. Eight sites were awarded planning grants in June 1992, each to be followed by either a one- or two-year implementation grant. Each is governed by an executive board or advisory council that includes agency representatives, parents, community members, and sometimes youth. In addition to making progress toward positive outcomes for individual children and families, the Centers are envisioned as pilots for a new form of service delivery that includes family case management, a common intake instrument, and a partnership of equals between families and service deliverers.

The creation of **District Health and Human Services Boards** in Florida's health and human services regions was legislated in 1992 (House Bill 2379) after the Office of the Governor and a number of commissions and task forces had investigated ways to reorganize the state's multi-agency Department of Health and Rehabilitative Services (HRS). The legislation specifies the composition of each board and how members are to be

appointed to ensure full representation of the multi-county region it will govern. The boards, comprised of agency, school, business, and private sector representatives, work jointly with their respective HRS district administrators. State funds are directly allocated to HRS, then distributed to the districts on a formula basis. Currently, no special monies are appropriated to support regional activity; boards are expected to seek other public and private local resources to supplement state dollars. The boards are intended to be new governance structures that work in partnership with the state to ensure substantial local decisionmaking, within broad statewide policies, regarding how health and human services are organized and managed to meet the needs of their unique regions.

The **Family Development and Self-Sufficiency Program** in Iowa is a joint initiative of the Office of the Governor and the General Assembly that has evolved beyond the demonstration stage and is entering its fifth year of implementation. The program, established through legislation in 1988, is a pre-crisis family preservation program that focuses on families at high risk of becoming long-term recipients of AFDC. It intends to support community-based, comprehensive, capacity-building interventions with at-risk families. Twelve local programs currently are receiving state grants, with additional monies obtained from the federal JOBS program and local organizations. Each program is affiliated with a community action agency, county government, or non-profit organization controlled by a local governing board. The major desired outcomes of the program are increased numbers of families that attain and sustain self-sufficient, nurturing family environments, and reduced numbers of children in need of foster care.

Kentucky's **Family Resource Centers and Youth Services Centers** are one component of the state's massive Education Reform Act of 1990 (House Bill 940). The legislative intent in establishing the Centers is to enable schools to deal with problems other than those directly encountered at school that might affect a student's learning. As of school year 1992-93, 206 school-based or school-linked Centers are receiving state funding to identify and coordinate a range of services in their communities to meet the needs of children and families. Each Center has a local advisory council that is at least one-third comprised of parents and also includes school staff members, special program representatives, and the community at large. The desired outcome of the Centers is the reduction of physical and mental barriers to learning for all children.

The **Children and Family Services Reform Initiative** resides in Maryland's Office for Children, Youth, and Families, created by the Office of the Governor in the late 1980s as a result of various efforts toward interagency coordination. In 1990, Senate Bill 389 required localities to establish collaborative planning entities to create and direct local interagency service systems. The intent of the Initiative is to provide better family-focused services to children who are presently in or at risk of out-of-home placement, and to begin to redirect funding streams and fiscal incentives away from inappropriate placements and towards community-based services. Local boards have the option of being a unit of county government or a quasi-public, non-profit organization. Members are appointed by the city or county's chief executive officer and include representatives from public agencies, the local school system, and local government. Local boards depend on a mix of state placement dollars (redirected from out-of-home-placements to local program services), general fund monies, and a variety of agencies' funds. Desired system outcomes of the Initiative are decentralized programmatic decisionmaking, flexible funding, and a partnership between families and local service deliverers.

New Mexico's **Communities in Schools** (CIS) initiative originated with a one-year grant in 1991 from the U.S. Department of Labor (DOL), Department of Justice, and national Cities in Schools office. The mission of the initiative (now housed in the Children, Youth, and Families Department) is to enable localities to develop and implement innovative and collaborative services and programs, with an emphasis on at-risk older children and youth. Four sites are currently funded. Each site is governed by a local board with at least half of the membership representing private entities. During the period 1992 through 1994, the state is using a smaller DOL grant, supplemented through a variety of local cost-sharing and interagency agreements, to provide seed money for new CIS communities. The desired outcome of the state's implementation of the CIS model is the development of a holistic approach to serving children, the entire family, and the community in a comprehensive manner through the use of such strategies as co-location of services, case management, and the creation of public-private partnerships.

Acknowledgments

The authors of *Finding Common Ground: Creating Local Governance Structures* gratefully acknowledge the assistance of several people in its production. We particularly want to thank Beverly Jimmerson, Governor's Policy Council, State of Texas; Saralee Tiede, Assistant Commissioner for External Relations, Texas Health and Human Services Commission; Ruthie Ford, Office of the Governor; Pat Anderson of the Texas Department of Protective and Regulatory Services; Liz Silbernagel of the Texas Department of Human Services; Kent Peterson, Council for Governors' Policy Advisors; Judith Chynoweth of the Foundation Consortium for School-Linked Services in California; and Boyd Ward, Deputy Director, New Futures for Little Rock Youth. Thanks go also to Lonne Parent and Artie Stockton at SEDL for their editorial support, and to Arleen Polite, an Austin, Texas artist, for design and creation of the wood engraving. Finally, we thank all respondents for their time and attention to this publication, and for their commitment to the children of their states (see Appendix, Interviewees).

Development of the Document

Target Audience. This Occasional Paper is intended to inform state and local policy- and decisionmakers in education and other public and private human services organizations.

Purpose. The document gives the target audience a set of profiles from eight states (Arkansas, California, Colorado, Florida, Iowa, Kentucky, Maryland, and New Mexico) that are changing the roles of state and local governments in the governance of systems that provide high quality, comprehensive services to children and their families. It is intended to help readers think about how they might apply the early lessons of these eight states as they consider the following questions:

1. What are some mechanisms or structures that my state (i.e. legislature; executive offices; state agencies of education, health, juvenile justice, and social services) might use to enable localities (e.g., city or county offices, regional commissions, local agencies) to govern systems of service delivery for families and children?

2. What are some policy strategies, structures, or mechanisms that localities might use in governing local systems that provide continuous, comprehensive services to children and their families?

State policymakers can use these profiles to learn how some states are working with local governments and service providers. Local policymakers and service providers can use them to inform their own efforts to assume new roles and responsibilities in the creation and governance of systems that provide high quality, comprehensive services to children and families. Readers also can use these profiles to share with and educate constituents, or to expand their network of contacts and resources.

Procedures. The work described in this paper has been carried out in collaboration with staff of the Texas Health and Human Services Commission, Texas Governor's Policy Council, and the Texas Department of Human Services. One question of interest to them is, "What sort of entities can the state create at regional and local levels to ensure local participation in service delivery?"

To help frame options in response to this question, Southwest Educational Development Laboratory (SEDL) agreed to collect information through informal, structured telephone conversations with representatives of state offices or agencies that have initiated new relationships between the state and local levels of government to strengthen services to children and families.

Potential respondents were identified from a review of literature, from SEDL's knowledge about such efforts in its region, and in telephone conversations with Judith Chynoweth, of California's Foundation Consortium for School-Linked Services, and Kent Peterson, of the Council of Governors' Policy Advisors (CGPA).

Respondents were first contacted by telephone to determine their interest and willingness to talk with SEDL staff. If they agreed, they received a copy of the conversation guide (see Appendix). Staff talked with key informants (N=13) in the eight states about the ways in which their state initiatives are organized to encourage local governance of service delivery (see Appendix, Interviewees). Issues included the following: (a) origin and history of the initiative, (b) mission and goals, (c) desired outcomes, (d) collaboration, (e) state functions, (f) local membership and organization, (g) decisionmaking, (h) accountability, (i) local functions, (j) service delivery, (k) funding, and (l) data collection. Informants reflected on the unique features of their state's initiative and offered opinions regarding the role the state must play in initiating and supporting local governance structures. They also provided artifacts (e.g., legislation, state plans, Requests for Proposal) that show how their states address many of the issues discussed in the informal conversations.

After the conversations, the information was synthesized—incorporating additional information from supporting documents provided by the informants. Drafts of profiles were mailed or faxed to the respondents for verification and clarification during the winter of 1992/93. After informants reviewed the drafts, they were shared with members of the Governor's Policy Council, Health and Human Services Commission, and Texas Department of Human Services.

Limitations. The profiles in this paper show the features of new local governance structures created in eight states. This effort to describe that landscape is exploratory in nature, and has neither the scope nor intentions of a case or field study. Furthermore, most of the efforts described are in early stages of formation or implementation. At this point in their development, these efforts are likely to experience great change and adaptation.

The profiles in this Occasional Paper were developed from September through November of 1992. The authors have revised the profiles for Arkansas, California, and Florida to include updated information; the other five profiles represent progress as of early 1993. By the time this paper is published, the initiatives described here probably will have made progress, modifications, or changes in response to their state economic and political climates as well as to the needs of their target populations. These eight initiatives will bear more robust investigation over time to update progress and to document the long-term impact of such efforts on children, families, professionals, and encompassing service systems. They can teach us what it takes to find and share common ground between state and local governments' responsibilities and efforts in serving children and families.

Conceptual Framework

> *The needs of "at risk" children seldom fall neatly into a single category. In addition to needing a strong educational system to succeed, children need adult support, attention, and love. They need proper nutrition and health care. They need a safe place to live. They need guidance in developing their identities, including a supportive peer culture. They need role models that demonstrate the benefits of work, learning, and self-discipline.* (Bruner, 1991, p. 4)

The health and social service needs of families have become inextricably linked to the educational success or failure of their children. As state and local policymakers seek ways to improve the academic performance of **all** students in their schools and districts, they find that significant numbers of children bring to the schoolhouse door problems that create barriers to their learning—barriers that schools are not prepared to address. This is not a new phenomenon. There has long been a recognition of the fact that "the physical and mental condition of the children, and their out-of-school experiences and behaviors, are powerful influences on their in-school performance" (Morrill, 1992, p. 34). Since the 1890s, educators, sociologists, medical workers, and a range of community activists have focused public attention on the need for children in poverty to have access to health and social services, as well as education, in order to become productive members of society.

Also since that time, schools themselves have been "attractive targets for reformers seeking to improve the health and welfare of children, for schools provided sustained contact with children and a captive audience" (Tyack, 1992, p. 21). Certain services once provided voluntarily by physicians, dentists, and nonprofessional philanthropic organizations now have become standard functions of the school: free and reduced-price lunches; counseling services; limited health services by a school nurse; and, in urban areas, the services of school social workers or "visiting teachers." The numbers of children at risk of school failure, however, appear to be growing, and many of these children have needs that surpass those that can be addressed by schools' limited non-academic services. These are the children with multiple problems that "cut across categories of service and involve health, mental health, education, employment, housing, nutrition, and social services" (Gerry & Certo, 1992, p. 119).

Policymakers are hearing a consensus from researchers and practitioners that "All facets of a child's well-being—safety, nutrition, physical, and mental health—are strongly related to achievement in school....But, schools alone cannot address the problems students and their families face" (Pollard, May 1990, p. 1). In searching for solutions, state leaders are taking a critical look at how health and social services are currently provided and experimenting with new designs for the systems that govern and deliver them.

The Current Structure and Delivery of Services

Without question many children in the United States have multiple needs that their first line of support—their families—cannot meet. Unfortunately, it is also true that public funds and services are not meeting their needs. Martin H. Gerry and Nicholas J. Certo of the U.S. Department of Health and Human Services claim that the health and human service system itself, which includes hundreds of federally funded categorical programs, is part of the problem. They cite the following five major system barriers to families benefiting fully from services (1992, p. 120):

1. There is no single point of access at the community level.
2. Individual agencies and programs fail to use a unified, interrelated, or holistic approach to meeting family needs.
3. Administrative obstacles within programs make it difficult to deliver services effectively.
4. Some categorical programs actively discourage or penalize efforts by families to assume personal responsibility by terminating services or benefits when families are just beginning to demonstrate success.
5. There is no single point of accountability in the system.

The way health and social services are currently governed and delivered at the state and local levels also has contributed to the mismatch between the needs of children and their families

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and the public systems that were created to serve them. These delivery systems are described by Melaville and Blank (1991) as fragmented **non**-systems, characterized by such dysfunctional features as:

- **crisis-orientation** which attempts to remediate problems rather than prevent their occurrence,
- **rigid categorization of problems** that fails to consider the interrelatedness of causes and solutions for an individual or his/her family,
- **lack of communication** among systems and the public and private service providers in each,
- **specialization of service providers** that renders them unable to devise solutions to complex problems, and
- **insufficient funding** to provide services for children and families with a history of multiple problems.

Osborne and Gaebler (1992) describe the irony in how such a troubled system came to be. The development of a health and social services system during the late 1800s was our nation's response to the needs of families and communities under stress at that time. Local, state, and federal governments took on the responsibility for initiating and managing some public health and social services, and a professional class of service workers began to emerge. The original intent was to **supplement the efforts of families, churches, and local volunteers** who were struggling to meet the needs of people in growing industrialized urban areas. However, the result a century later is a system governed by those in public office and implemented by professionals. Individual and community resources have become the **supplement to public services.** This reversal in locus of responsibility has resulted in a slow but certain distancing of the community from its members in need. What began as a remedy for the community's weaknesses has become a replacement for its strengths.

Over time, the specialization and categorization of government-provided services have created an even wider gulf between communities and their children and families who need support. The federal approach to providing services by entitlement, and using categorical funds to channel resources to states, has been imitated at the state level. State agencies provide funding and services in highly prescriptive ways, and provide minimal authority and resources to local governments to coordinate the many categorical services in their communities. Those few local governments that **do** have a major role in service provision tend to follow this same approach when faced with new and difficult community problems; they create specialized programs for narrowly defined populations.

Consequently, throughout the system, "no clear policy directions are available as a framework within which resources can be invested. Agencies do not work toward common goals that cut across agency boundaries to help either an individual family or to advance a broader community policy" (CSSP, 1991, p. 4). The profusion of state and federal agencies that carry out their own goal setting, planning, and service delivery has created a set of discrete local services characterized by:

- differences, even contradictions, in the diagnosis of family problems;
- solutions that are too narrowly focused;
- problems that are ignored because they fall under "somebody else's" purview; and
- clashes in philosophy and approach among deliverers.

In considering the source of turmoil in the federal-to-state-to-local stream of services to children and families, the Center for the Study of Social Policy (1991) asserts that federal and state services have been mandated without attention to local needs for direction or the infrastructure necessary for successful implementation. "No one is in charge of local community services for children and families. No one governs the totality. No one has overall responsibility for overall outcomes" (p. 3).

The Importance of Community—Changing Systems to Share Responsibility

Today, government is beginning to reverse this trend. In the 1970s and 1980s, the U.S. Department of Health and Human Services made the integration of health and human services a priority in its efforts to improve the outcomes of government-funded programs. The focus initially was on improving program

administration and strengthening state and local service provision capacity; that is, improving performance at the management and professional levels (Gerry & Certo, 1992). The failure of this approach to significantly improve client outcomes led to the current emphasis on developing a client-centered decisionmaking approach that increases "family self-sufficiency through direct involvement of the family in the planning and evaluation of services" (p. 121). Gerry and Certo suggest that this approach is possible only through "the creation of a **neighborhood school- and community-based support system**, [emphasis added] which stresses personal responsibility and adopts a comprehensive approach to meeting the needs of families" (p. 122).

The belief that service systems need to be a public responsibility shared with families, schools, and communities rather than a government responsibility is driving change in the education system as well. Although education has long been the responsibility primarily of states and localities (i.e., school districts), a growing movement to further decentralize authority and accountability is underway. Many proponents of school-based management and shared decisionmaking emphasize the participation of parents, community members, and even older students on school and district decisionmaking teams. The goal of shifting ownership and governance from the state to the school community is "to provide **local districts and school sites** with the flexibility, authority, and resources they need to develop **learning opportunities** that address the problems and meet the needs of their community of students" (Duttweiler & Mutchler, 1990, p. 76).

The decentralization of decisionmaking and accountability in the health and social service system is intended to meet a similar goal: to provide **local communities** with the flexibility, authority, and resources they need to develop **strategies for service delivery** that address the problems and meet the needs of their children and families. Current federal activity in the health and social services arena clearly reflects this shift in responsibility and discretion, with increasing opportunities (and demands) for states to experiment with new ways of improving service delivery outcomes for their citizens. The intent is not to eliminate governmental responsibilities in the system, but to rebuild the community's role in making the system work.

Decentralizing decisionmaking and accountability is not an attempt to return to the service model of the 1800s. The United States of the 1990s can never again rely solely on churches, civic service groups, and other philanthropic organizations to provide services to those in need. The expertise and experiences of health and social service professionals will remain essential resources in efforts to meet human needs. However, community ownership and involvement in governing health and social services must be central to the development of any new system that can better meet the multiple needs of children and families who are living in the margins of society.

A unique level of complexity exists in building community capacity to share responsibility for service delivery. The current health and social services "system" actually consists of multiple hierarchical systems. These systems differ from state to state but may include such separate agencies and commissions as: social services; health; juvenile justice and corrections; services for the aging, the blind, the deaf, and hearing impaired; mental health and mental retardation; early childhood, youth, and rehabilitation. Health and social services reorganization will require shifts among multiple massive systems as well as between the state and local levels in each, before community ownership and governance of services can be more than a localized phenomenon.

As states respond to pressure from the federal government to shoulder greater responsibility and set new goals for services integration, attempts to reform these complex systems are being undertaken. Some states focus on changes at the state level through such actions as: initiating bureaucratic reorganizations; shifting major areas of authority and responsibility from one level of government to another; and using block grant strategies (CSSP, 1991). Others are exploring ways to begin at the community level—providing local communities the means to create and govern innovative programs appropriate for their citizens. A number of these state initiatives includes the creation of different types of local governance structure to serve as mechanisms for building community capacity.

State action to support and nurture local governance is based on the belief that "when communities are empowered to solve their own problems, they function better than communities that depend on services provided by outsiders" (Osborne & Gaebler, 1992, p. 51). The expectation is that when governments enable

their communities to reclaim social problems, they empower them to rediscover the strengths inherent in "community": commitment, understanding of local problems, a problem-solving rather than service-provision orientation, caring, flexibility and creativity, efficiency, shared values, and a focus on human capacity rather than deficiency (Osborne & Gaebler, 1992).

When governments enable their communities to reclaim social problems, they empower them to rediscover the strengths inherent in "community."

Local Governance Structures—Mechanisms for Building Community Capacity

A local governance structure is an organization or interorganizational arrangement at the regional, county, or local level that might include any combination of state, county, or local governmental agencies, and private for-profit and/or nonprofit agencies. A local governance structure has autonomy or discretion over: (a) local allocation of resources; (b) local decisionmaking; and (c) local service delivery, but maintains some type of relationship with agencies at the state level. Such structures or entities are "the vehicles through which community services incorporate an on-going process of change....They are the mechanisms by which public agencies, acting in concert, can set directions, marshall resources around common goals, integrate service providers' efforts, and monitor their own success" (CSSP, 1991, p. 1).

Melaville and Blank (1991) describe the ultimate goal of local governance structures as a high quality, comprehensive, seamless web of services. Such a system of service delivery is characterized by the following essential elements:

- Easy access to a wide array of prevention, treatment, and support services
- Techniques to ensure that appropriate services are received and adjusted to meet the changing needs of children and families
- A focus on the whole family
- Agency efforts to empower families within an atmosphere of mutual respect
- An emphasis on improved outcomes for children and families.

Clearly, the creation and governance of a comprehensive, integrated local system of service delivery go beyond the coordination of services to include authority over fiscal matters and evaluation. A local governance structure can be the unifying force in a community "through which emerging problems can be identified as they are encountered individually by agencies, analyzed for their impact on a wide range of families rather than just a few categorical target groups, and strategically resolved on a community-wide basis" (CSSP, 1991, p. 5).

Local governance will appear in no single common form, but tends to be interpreted as a community-based, rather than institution-based, model. Chaskin and Richman (1992) present both a philosophical and practical rationale for separating the idea of a local governance structure from the more familiar school-linked services model:

> If we see the planning, promoting, and provision of the full range of children's services and opportunities as the responsibility of the community rather than of a single institution, that responsibility can become a vehicle for enriching (or even creating) community. Such an approach could foster mechanisms for promoting involvement in the community. In addition, community involvement could provide for and respond to the needs for diversity among the residents of a community and weave together from many institutions and interests a rich infrastructure to support children and families. (p. 116)

Local governance structures can also be expected to take on a variety of different functions, based on the needs of their unique communities. However, the Center for the Study of Social Policy (1991) suggests that there are four key functions of **any** local governance structure: (1) agenda setting and strategy development around high-priority community problems; (2) developing new service capacities to meet family needs more effectively; (3) coordinating fiscal strategies to support the community's service agenda; and (4) maintaining accountability for family and child outcomes. An elaboration of these functions follows.

Agenda setting and strategy development. Three major differences distinguish agenda setting by a local governance structure from traditional community planning and action (see illustration below). First, the local governance structure

defines problems in broad terms. Decisionmakers focus on conditions that create a problem for families and children and target desired outcomes for those families and children rather than for the systems that serve them. The problem(s) selected for action are concerns common to community leaders and residents. Second, goals, priorities, and strategies are developed with the involvement of community members and in a comprehensive manner—one that "reaches across agency and organizational boundaries and deliberately involves multiple systems of care" (CSSP, 1991, p. 8) in addressing the problem wherever it appears throughout the entire community. All agencies and community organizations are considered potential contributors to the solution. Third, the governance structure uses its influence and authority to ensure that selected strategies are implemented. Goals and strategies are widely communicated among agencies and the public at large to build shared understanding and commitment throughout the community. Agenda setting is at the heart of the potential power of a local governance structure: it enables the community to come to "agreement on problems and to create more effective methods of achieving desired outcomes for families and children through improved and more comprehensive service strategies" (CSSP, 1991, p. 7).

Developing new service capacities. Local governance structures work to maximize current services and systems in order to create a more comprehensive, flexible system of service delivery. To accomplish this goal, localities are finding the need for new processes and procedures that will enable the system to better respond to the needs of families and to operate more efficiently. Inasmuch as these service capacities need to cut across multiple agencies and service providers, the local governance structure may be the single entity most capable of performing this function.

The Center for the Study of Social Policy identifies two new capacities in particular as emerging in importance: interagency case management and common family assessment. **Interagency case management** is the local governance structure's ongoing use of aggregated information collected by family case managers to identify critical barriers and gaps in the delivery system and make decisions regarding the appropriate direction of resources. The Center suggests that case managers work directly for the local governance structure. This application of the case management model creates a mechanism for directly linking policy to practice at the local level: it becomes a vehicle for system change as well as service improvement for individual families.

The second emerging capacity, a **common family assessment process**, is a tool used by family case managers and agencies to create a single point of entry for families into the local system of services. The process may include such components as a common intake instrument, shared data base, and cross-agency training to ensure consistent implementation. Common family assessment not only simplifies access to services for the families, but also benefits the various service deliverers by enhancing their communication, increasing efficiency, and even uniting their service delivery philosophies.

Coordinating fiscal strategies. The local governance structure must develop fiscal strategies to ensure that available resources are directed to support its agenda. Strategies include:

Agenda Setting and Strategy Development

Local Governance Structure Planning and Action	Traditional Community Planning and Action
• Selects fundamental problems of importance to the community and defines them in terms of outcomes for children and families	• Tends to focus on "a pre-existing and usually small-scale definition" (CSSP, 1991, p. 8) of a narrowly focused problem
• Collaboratively devises comprehensive solutions that involve all appropriate service systems	• Tends to develop solutions that involve only one or two service systems
• Directly engages agency and community support and commitment for implementing the plan	• Tends to rely on other entities to take action on the proposed plan.

maximizing existing dollars (e.g., coordinating fiscal decisions among different agencies, pooling resources); maximizing federal entitlement funds for which the community qualifies; reinvesting savings gained through maximizing existing state and federal funds; and seeking additional funds.

Maintaining accountability. This final function is the governance structure's effort to create a feedback loop via a process of self-evaluation. The entity sets and tracks outcome measures related to the goals set for children and families, and the selected indicators of local system performance. The purpose is to hold the entire, multi-agency community service system accountable by systematically using information from performance tracking to make "ongoing adjustments to agency practice, policy, and funding" (CSSP, 1991, p. 15). The governance structure must ensure widespread dissemination of assessment results to (a) build community awareness and commitment to solving pressing local problems; (b) celebrate successes; and (c) enhance the credibility of the local governance structure itself. As more technologically sophisticated data systems emerge, they will enable local governance structures to more rapidly and accurately chart and correct their course.

State Support for Local Governance

States are experimenting with various local governance structures as they seek ways to encourage local control of health and social service delivery. Osborne and Gaebler (1992) described former Secretary of Housing and Urban Development Jack Kemp's strategies for helping communities manage the transition from professionally managed public housing to tenant management and even ownership of their developments. The government's role is not to "abandon services delivered by bureaucrats and professionals," but to "remove the barriers to community control; encourage organized communities to take control of services; provide seed money, training, and technical assistance; and move the resources necessary to deal with problems into the control of community organizations" (Osborne & Gaebler, 1992, p. 71). Many of these same strategies are being used by legislatures and governors' offices throughout the United States to initiate the development of community capacity for local governance of health and social services.

Some states that are establishing local governance structures have taken what Bruner (1991) calls the *third-generation* approach to promoting collaboration: they are implementing collaboratives statewide among multiple jurisdictions. This approach necessarily includes those communities where "eagerness [to adopt collaborative approaches] does not exist and where obstacles to collaboration are greatest" (p. 20). For example, each Health and Human Services Region in Florida is creating a District Health and Human Services Board. Although a regional structure has existed since 1975, decision-making entities such as the district boards are new, and some regions will need more encouragement and assistance from the state than others.

Most states are beginning with second-generation demonstration projects, using incentives and other "top-down strategies for supporting bottom-up services" (Bruner, 1991, p. 17). This approach tends to focus on multi-site demonstrations or pilots whose activities and outcomes can inform state policymakers as they attempt to design a state-wide approach to reforming the health and social service systems. The state provides guidelines, technical assistance, flexibility, time, and incentives to communities that generally are ready and eager to build on a foundation of community interest or support that already exists.

The demonstration or pilot nature of some local governance structures does not suggest that they are viewed as temporary or as peripheral to the real business of improving the delivery of health and social services. Whether individual local entities or members of a new statewide system, local governance structures are efforts to achieve "a permanent consolidation of leadership and decision making that is needed within local communities to find better ways of delivering services to vulnerable populations" (CSSP, 1991, p. 1). They are working with a dual purpose: to improve the delivery of health and social services to children and families in their jurisdictions, and to contribute to the creation of a state system that enables **all** communities to accomplish this purpose.

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Arkansas

Arkansas Families First

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Arkansas

History

In 1988, Arkansas began working on welfare reform, particularly as it related to implementation of the Family Support Act. Arkansas also was one of 10 states that participated in a Policy Academy sponsored by the Council of Governors' Policy Advisors (CGPA), then called the Council of State Policy and Planning Agencies. The Policy Academy provided training in how to collaborate, develop better communications, and plan across agency and division lines.

Subsequent to the first CGPA planning session, former Governor Bill Clinton appointed the Arkansas Family Policy Council, which consisted of representatives of various state agencies, the General Assembly, and the community at large. The council developed goals and initiatives related to family support and began to look at statewide programs that could help accomplish these goals.

A program that responds to one of the Family Policy Council's goals is the Arkansas Families First program. Act 1, passed during a special legislative session in 1992, appropriated funds that enabled 13 communities to each establish a local family policy team and hire a community coordinator to develop and direct local efforts to serve families at risk.

Mission & Goals

The Family Policy Council established a Families First mission statement: "All families in Arkansas will be able to adequately provide mutual support, care, and protection for the family unit." The Council also set the following five goals for Arkansas families:

Goal 1: All family members will be part of a health care system which provides for preventive health care as well as needed acute care.

Goal 2: Parents will have access to the training and support they need to effectively serve as their child's first teacher and to devote time each day helping their children learn.

Goal 3: All adult family members will have the opportunity to acquire the knowledge and skills needed to adapt to emerging new technologies, work methods, and markets.

Goal 4: Families in Arkansas will be free of drugs and violence.

Goal 5: Families will find it easy to choose and obtain the services and skills they need.

Desired Outcomes

The Families First goals have specific objectives or desired outcomes associated with them, some of which have been already realized. For example, under Goal 1, the desired outcomes are "To increase the number of families covered by public or private health insurance" and "To ensure every child has a regular physician or clinic." Action by the state to date has resulted in improved screening of children for the Early and Periodic Screening and Diagnosis and Treatment Program (EPSDT) and Medicaid. Three years ago, Arkansas was only screening around 20% of its eligible children; by fall 1992 approximately 60% of those eligible were screened. Such progress has been due to policies and initiatives developed collaboratively by the Department of Health and the Department of Human Services (DHS).

In order to meet Goal 5, the Governor's Office decided to focus on interagency coordination by encouraging the development of a new kind of local structure for community planning and action. Communities were invited to form local policy teams and submit proposals to implement local Families First initiatives. Initially, the intention was to fund just two sites. However, a $300,000 appropriation made during the 1992 special legislative session allowed 13 community-based pilot program grants to be awarded. This was followed by an unexpected appropriation in 1993-94 that will allow a reduced level of funding for some or all of the 13 sites.

Arkansas Families First

Collaboration

One intention of the Arkansas Families First initiative is for the Governor's Office, through the Family Policy Council, to combine efforts with the departments of Health, Human Services, Education, and Employment Security to meet some common goals (among them, the five Families First goals) by the year 2000. One example of collaboration between these agencies is the joint effort of the Department of Human Services and the Department of Education to provide screening for and expand EPSDT services.

The state has entered into agreements with individual school districts, designating them as Medicaid providers who bill Medicaid for services rendered to eligible children. As a result of these agreements, the state spent about $4 million in 1991 on Medicaid in the public schools. Sixteen districts were participating in fall 1992 and the number is rapidly increasing as more superintendents recognize the benefits of this arrangement. For example, all districts employ school nurses and many have hired speech therapists and other specialized personnel to meet their obligations to special education students under PL 94-142. Districts benefit from additional funding for services such as these that they already provide, and the state benefits from the increased accessibility of medical services to children and families.

State Functions

The legislation that funded the local Families First initiatives directly stipulates that the grant money must be used to hire a local coordinator to coordinate state, local, and federal programs serving families at risk. Family Policy Council staff help meet other needs of local policy teams by providing a training and technical assistance support system for the teams and their coordinators. In the first year of the initiative, the Council focused on encouraging and motivating the teams and helping them develop their planning and decisionmaking capacities. In the second year, teams will need assistance in building on and expanding the local collaboratives they have created.

In 1992, a two and one-half day academy similar to the CGPA academy was held in Little Rock for communities that were interested in applying for the Families First grant. Members of the Family Policy Council served as coaches, and CGPA staff provided coordination assistance. The goal was to teach collaboration skills. As a result of the academy, trainers and Council staff recognized the need to help communities overcome barriers in certain areas in order to successfully build collaborative relationships. Difficulties included: lack of trust regarding the state's intention and commitment, inexperience with identifying local problems and setting priorities, and lack of communication among organizations and agencies (and thus unfamiliarity with each others' goals and activities).

After the 13 sites were selected, local policy teams were convened separately in their communities to discuss and refine their individual plans. Each community was visited three times to help teams focus more clearly on local needs, identify ways they can change and improve services, and build communication and collaboration skills. Family Policy Council staff also met with local supervisors in Economic and Medical Services and other divisions that have county offices to communicate the state's commitment to supporting the communities and to encourage local commitment.

Team leadership from all 13 communities then met separately in Little Rock with the state Family Policy Council staff to discuss their refined plans, expected outcomes, and implementation strategies; and to continue to build a relationship of mutual trust that will enable them to take the risks necessary to achieve those outcomes.

Finally, the state is using a number of strategies to motivate the local teams as they work to collaboratively implement their plans. Regional technical assistance workshops brought a number of local policy teams together to work on common issues. Each community has been paired with another to facilitate a closer networking relationship. A newsletter created an avenue for communication among all sites, as did the dissemination of phone numbers of state Family Policy Council members, local policy council team leaders, and project coordinators. Local representatives of state agencies also met together to determine their roles in ensuring the success of local Families First plans.

Arkansas

Membership & Organization

At the state level, the Arkansas Family Policy Council is composed of one representative from the Department of Health; three representatives from the Department of Human Services (the Director's Office, Economic and Medical Services, and the Office of Children and Families); the director of Employment Training Services under the Employment Security Division; the Associate Director of the Department of Education for Special Education (representing general education); and the Governor's Office. These are not cabinet members; they directly represent their agencies and carry the authority to initiate inter-agency collaboration as a result of a specific Council decision.

At the local level, the intention from the beginning was to make the Families First grant program a community effort, not a state government effort. It was presented as a partnership between the community and the executive branch in cooperation with the General Assembly. To accomplish this, a letter announcing the grants was sent out from the Governor's Office directly to the mayors' offices throughout the state. Act 1 states that the Department of Health and the Department of Human Services, as well as appropriate local officials, must participate directly in the local effort. By regulation, the Job Training Partnership Act (JTPA) also must be part of the local team. Thus, the local policy team at each site has a member from DHS, Health, the school district, and JTPA. Remaining membership is at the discretion of the local team.

Local teams are composed primarily of individuals who were on the original teams that attended the local Policy Academy in June 1992 and collaboratively wrote their community plan. Many teams are rapidly expanding to include members from the police department, fire department, other community agencies, and city government. Some teams have the mayor or city manager as their team leader.

Most teams demonstrate a strong commitment to collaborating and institutionalizing their local effort. State agency team members now consider participation on the team as part of their jobs. Teams meet regularly—some once a week, others twice a month. They demonstrate not only a close relationship with their local coordinators but also a better understanding of each other's organizations and agencies.

Decisionmaking

Local Families First policy teams have authority over policy related to the team and its activities: the team's organizational structure, its community plan, and strategies to implement the plan. The only decisions made by the state have been those related to determining which sites receive funding.

Local teams have the ability to influence the way state services are delivered by bringing requests for changing state processes (e.g., the location or configuration of state services) directly to the Family Policy Council. If a change doesn't require a waiver, the Family Policy Council can direct state employees at the local level to make the change. If a waiver is required, the Council can facilitate the necessary process.

Groundwork has been laid to ensure the greatest possible flexibility for local teams in their relationships with federal agencies as well. Though a mechanism was not established in the Act 1 legislation, the state Family Policy Council is committed to encouraging this type of local decisionmaking.

Accountability

The Family Policy Council is engaged in ongoing work with local policy councils. Each community's plan includes specific outcomes and established timetables for implementation. Councils report quarterly to the Department of Finance Administration on how the grant money was spent, and a final report is provided at the end of the fiscal year.

The intent of the legislation is to coordinate services, and the Family Policy Council's goal is to enable local councils to experience success by identifying what doesn't work, making appropriate changes, and seeing improvement as a result. It is believed that this is a process that will take time and will require continual local monitoring and adjustment of plans. At this time there are no penalties for not achieving outcomes. There may be turnover in council membership and leadership; timetables can change; even major goals and expected outcomes are open to alteration. The entire Families First proposal has changed at a number of sites. In most cases, Family Policy Council staff view such changes as improvements.

> "*We don't see the coordinator as being that vital, if the teams are made up of the proper members—in other words, the people who deliver services and the people who can make decisions at the local level. We anticipate that this will have as significant an impact as our interaction here at the state level has had with the other agencies. That has been a tremendous impact. I have worked in government for about 24 years and I'd say that there has been more collaboration, more cooperation, between the state agencies in the last three than I've seen at any time.*"
>
> Kenny Whitlock
> Director
> Economic and Medical Services
> Department of Human Services

Local Functions

The major function of the local Families First policy team is to oversee its community plan. Each team serves as a board that directs the local program. Teams develop the coordinator's job description and hire their coordinator. Teams assess community needs to identify service gaps and determine how current services can be delivered more effectively (e.g., expanding agency office hours, changing the location of service delivery). Public relations is a major function, particularly to educate businesses and community organizations regarding local needs and their role in meeting those needs.

Arkansas

Service Delivery

While traditional health and human services are provided by the local offices of state agencies, local Families First teams are encouraged to develop and facilitate the provision of new services by local volunteers or existing community service organizations (e.g., the Rotary, Big Brother). A great deal of importance is attached to these avenues for providing services at the local level—not only to supplement current services but also to create more personalized, locally relevant services.

Funding

The $300,000 special appropriation in 1992 provided each Families First site with a one-year grant that primarily funded the program coordinator's position. When the money was awarded on July 15, 1992, all but four sites received $25,000; the other four received about $18,900. Though communities were assured only one year of funding, the 1993 General Assembly appropriated an additional $244,000 for each year of the next biennium. Of these new monies, $146,000 can be spent in 1993-94 for the Families First local initiatives. These funds will be distributed among local sites, with some portion directed to providing training academies and technical assistance to all sites. The original 13 communities will be asked to submit a second year proposal, committing to continue and expand the interagency collaboration they initiated and implemented during the first year. Depending on local interest and commitment, the number of communities involved in the project may change.

During the first year, funds were administered through the Department of Finance Administration in the Department of Education. During 1993-94, monies will pass through the general education division of the Department of Education to the Children and Family Life Institute, a division of the Children's Hospital. The appropriation bill requires that the Departments of Human Services, Education, and Health continue to coordinate efforts in administering the program. The Family Policy Council out of the Governor's Office also may remain involved in Families First as it continues to look at ways of better coordinating services to children and families in Arkansas.

Family Policy Council staff are not certain how local teams may use their second year funding. A number of communities experienced great success with their coordinators and had already begun to look for ways to support this position beyond the first year. Other communities may find the position is not essential to their program's continuation. Council staff hope that the development of a strong local team, accomplishment of some local service delivery changes, and forging of new relationships among agencies will enable teams and their communities ultimately to function successfully without a coordinator, if necessary.

The Council and local teams continue to expect an end to state support in the future and are looking at other possible sources of funding. On a local level, JTPA appears to be an underutilized source of funds. Communities are being urged to respond to its Requests for Proposal (RFPs) individually. Local businesses are another potential source of support. Also, as local policy teams become more familiar with the budgets and the goals of local agency offices, they may find ways to continue funding for the coordinator position.

Data Collection

The challenge of Arkansas Families First is how to use existing resources to better serve families in communities. There is an explicit effort to avoid creating the same level of bureaucracy already seen in other service programs. Furthermore, the Family Policy Council is reluctant to establish an extensive reporting system that requires administrative costs that local policy teams cannot bear. Thus, quarterly reports regarding activities and community needs are required, but numbers of cases served and other such data are not expected.

> *"They [local policy team members] don't quite believe that the ability to really change the system is in their hands. This is a unique time for them to begin to realize their community's potential. By connecting the viability and the health of these families to the viability and health of the communities, we have been able to bring in some new players—[particularly] the mayors and city managers."*
>
> Ann Kamps
> Special Assistant
> Family Policy Council
> Office of the Governor

Unique Features

Local Families First implementations are a low cost attempt to get the local community involved in the delivery of services. As one Policy Council staff member stated, "The key has to be getting the community to accept the fact of responsibility, and that through these kinds of services our community will be better off. The people that live in the community must associate these services and this effort with how they are going to be better off themselves—not [just] somebody down the street or across the tracks."

Nothing was legislated other than the small amount of start-up money. No one has been told it is something they have to do; nothing is mandated. It is a program of commitment, initiated and encouraged primarily by the members of the Policy Council who want to pass their beliefs on to the local level. Local teams act out of "a sense of commitment to their community, the way the Policy Council is committed to the state."

Finally, the strength of the local team is critical. Teams must deal with such issues as attitude problems; racial and other barriers; and concrete social, health, and education problems of the community. In Arkansas, "the relationships among Family Policy Council members are marked by trust and mutual respect. If we can recreate that on the local level, there is no problem that can't be worked out."

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State Role

A state interested in supporting an initiative such as Arkansas Families First must be ready to make a commitment to state and local collaboration, which is not a quick or easy process. The right people—those who have the ability to cause change—must be identified and convened to talk about real problems in the state and individual communities, not just the symptoms of these problems. Then these people must determine how the state and local governments and the community can work as a team "to identify those things that the community [agrees are] unacceptable, and determine what the community can do to stop them from happening."

A body such as a state council or similar state-level entity may not be necessary to guide or support the development of local governance structures. Successful initiatives can be directed out of one office. However, more work may be involved because other players will need to be won over one at a time. A council brings them together from the beginning. Also, a council might be less vulnerable to political changes than an individual office holder or agency head.

California

HEALTHY START
(Senate Bill 620)

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California

History

In the decade preceding the passage of Senate Bill 620, the Healthy Start Support Services for Children Act, the California Legislature had been considering approaches to improving the coordination of services for children and families. The Select Committee on Children and Youth studied policy development strategies related to children and youth and proposed a number of bills. The committee was successful in securing legislation that reformed many programs and provided local government with flexibility and incentives to coordinate local services for children.

Children's issues also were a priority of California's Governor, Pete Wilson. In 1991, the Governor designed a 10-point initiative in which Healthy Start was the linchpin. His objective was to use schools as the focal point to coordinate services to children. Dr. Jane Henderson, then with the Select Committee, was brought in to draft the Healthy Start initiative in Senate Bill 620 and later was asked to implement the program. Healthy Start was signed into law by Governor Wilson in 1991 and became effective on January 1, 1992.

Mission & Goals

A major objective of Healthy Start is to provide more flexibility in the delivery of services to children and families, while focusing on prevention more than intervention. The goals of Healthy Start are twofold: (a) to improve psycho-social, health, and educational outcomes for children; and (b) to create systems change in order to accomplish the first goal. The primary objective of the latter goal is to reshape bureaucracies so that they are more responsive to children and families. Together, these goals acknowledge that if children are to be helped, their families must receive support.

The Healthy Start program is targeted at low-income and limited English proficient students. The mechanism chosen to accomplish program goals is the coordination of services at or near a school site. The school provides a friendly and convenient place for families. Implementers in California's school-based approach are required to ensure that parents are able to participate and that systems designed to provide services are culturally sensitive.

Desired Outcomes

Overall, the Healthy Start initiative hopes to achieve improved physical and mental health as well as better social and educational outcomes for children. A comprehensive, outcome-based evaluation has been devised that takes into account specific items such as referrals to the justice system, health care providers, and social services, as well as various poverty indicators related to the family.

California's work on its evaluation design has revealed the difficulty in establishing direct linkages between services provided and observed changes in a family's circumstances. For example, it is difficult to prove a causal relationship between the provision of family support services in a neighborhood school and fewer instances of child abuse among the students' families. One component of the state's evaluation of Healthy Start is a longitudinal study that will examine such linkages (see section, **Accountability**).

Healthy Start (Senate Bill 620)

Collaboration

In the process of implementing its state Healthy Start program, California is a potential collaborator with other states in reforming the federal Medicaid system. The National Association of School Boards, in conjunction with the American Medical Association, is trying to support networking among California and other states that are creating comprehensive school-based services (CSBS) programs. California's goal is to develop a CSBS program that "improves access to school-based health services for Medi-Cal eligible children, assists the Department of Health Services in meeting federal mandates, and is financially feasible." Other states involved also have created a Medicaid school-based provider type or are attempting to create one. The intention is to create a system that eliminates restrictive eligibility requirements. For example, rather than continue to provide health services on a fee-for-service basis, an entire school or district could be declared Medicaid eligible if 70-80% of the student body meets specified poverty indicators. Networking with other states on this issue will provide useful information that can be used to lobby for broader system change that ultimately will require federal approval. The Department of Health Services in California is taking the lead in developing this new Medicaid provider category.

The California Department of Education is attempting to build a strong pattern of collaboration with other state agencies that are involved in the Healthy Start initiative. The Department has the mandate to administer Healthy Start but does so based on the recommendation of the Secretary of the Health and Welfare Department, who oversees social services, mental health, and other health services along with the Secretary of Child Development and Education.

To date, efforts at interagency collaboration have been difficult and time consuming but successful. Significant progress has been made in developing an appropriate structure for making policy, fiscal, and program decisions at the state level. A Principals' Group has been formed, including the State Superintendent of Public Instruction; the Secretary of Child Development and Education; the Secretary of the Health and Welfare Department; and the Directors of the Departments of Health Services, Mental Health, Social Services, and Drugs and Alcohol; as well as the heads of their key departments and representatives of private foundations. The Principals' Group meets on a monthly basis. In addition to the Principals' Group, there also are weekly staff meetings of top-level people who report directly to state decisionmakers.

State Functions

A statewide initiative such as the Healthy Start program requires considerable effort in the areas of technical assistance and evaluation. A field office has been established to oversee and coordinate these functions. The field office, operated through an interagency agreement between the California Department of Education and the University of California, Davis, is responsible for providing technical assistance to local sites who have received operational or planning grants. Pregrant assistance to those who are interested in applying is provided through the Request for Proposal (RFP) process and statewide conferences. The field office also acts as a clearinghouse for information dissemination. Though the office is an arm of the California Department of Education, it is allowed flexibility in responding quickly to local needs. In Fall 1992 there was only one field office, but it was anticipated that another one might open as the program grows.

The Healthy Start initiative was written to maximize local ability to be innovative and collaborative. Local networking is emphasized as much as possible, and thus additional technical assistance is provided through a regional network of trainers.

The state provides another type of support to local sites through county "realignment" legislation that went into effect more than a year ago. Counties have 90% authority to implement health and human services programs. The realignment legislation provides counties with funding through a redirection of vehicle licensing fees and other taxing authority. The realignment process allows counties to receive state money for providing mandated health, mental health, and social services in a block grant rather than as categorical funds. The legislation also allows counties to transfer up to 10% of their funds from one service area to another (e.g., social services to health services), if there is a need. Thus, counties now have more flexibility and authority in spending public funds related to service provision.

Finally, California is fortunate to have resources and support provided through the Foundation Consortium for School-Linked Services, a consortium of twelve or more private foundations in the state who are interested in the Healthy Start Program and other efforts to foster comprehensive, integrated, school-linked services. Members of the Foundation Consortium serve on the Principals' Group, participate in staff advisory group meetings, and serve on subcommittees that deal with technical assistance and evaluation. The Foundation Consortium provides funds for technical assistance to the state as well as to individual local sites, and provides significant revenues toward both program and site evaluation.

Membership & Organization

The Healthy Start initiative requires local programs to be designed based on a clear assessment and understanding of local needs; therefore, stipulations concerning the formation, membership, and organization of local collaboratives are minimal. Legislation requires that the grantee establish a local collaborative composed of representatives of public and private agencies that are involved in providing services to children and families. Legislation also requires parent and teacher participation in the collaborative.

Decisionmaking

There are very few mandates regarding decisionmaking in the Healthy Start legislation. A great deal of flexibility is built into this component. Healthy Start grantees have autonomy regarding the structure of their program, as long as all aspects of the program are focused on meeting the needs of children and families. The specific population to be served also is decided by the grantee.

Members of the collaborative decide who will convene the meetings and determine the place and time. Local collaboratives develop policy and establish their own plans and strategies for achieving outcomes. They decide who will make decisions about problems that arise and if decisions will be made by consensus or by a lead agency.

Local Governance Structure

Accountability

Senate Bill 620 requires an independent, statewide evaluation of the Healthy Start initiative. The evaluation, conducted by SRI International and funded by the Foundation Consortium on School-Linked Services, focuses on two areas: (a) outcomes (for children, families, service providers, and schools), and (b) the systems change process.

The outcomes component of the evaluation is intended to capture both local outcome data and aggregate data across sites at the statewide level. Design was challenging because outcome measures among local programs vary greatly. The program is a K-12, statewide initiative. Individual implementations are unique according to the grade levels served and their geographic location. Also, Healthy Start funds go to a school district or county office of education on behalf of one or more schools under their jurisdiction. Thus, a program may be a single elementary school or a cluster of three or four. In one area, up to 11 schools are working together to establish one family resource center. This evaluation component includes a longitudinal study of children and their families that examines education, health, and social outcome measures.

The process component of the evaluation is a qualitative study of the collaboration process as it develops at both the state and local levels. Data are collected through surveys and interviews to provide a descriptive analysis of system change over time.

SRI International also will create a uniform statewide data base, assist the Healthy Start operational sites (now 65 in number) in evaluating their efforts, and provide other assistance to 110 sites that have been awarded planning grants. The field office at the University of California, Davis, works closely with SRI to provide technical assistance to sites in response to ongoing evaluation results. SRI provides quarterly reports on each site and on the overall initiative. A report to the Legislature is expected June 1, 1994.

Local Functions

A major function of Healthy Start collaboratives is to conduct a needs assessment of the children and families in their locality. Another basic function is to determine a better way to link children and families to the services they need via the school system or a referral service. Case management and interagency collaboration are major strategies that collaboratives use in performing their linking function.

Service Delivery

The type and mode of service delivery depends in large part on the make-up of the Healthy Start program and its community. Most sites presently receiving operational funding have a health services component. Many also have a strong family services component. Depending on community needs, other areas of service delivery might include: (a) parenting education, (b) vocational education for parents, (c) substance abuse programs, (d) housing and employment assistance for parents, (e) recreation, (f) child care, and (g) mental health services for children and families.

Funding

Healthy Start funds are provided through the California general fund, with additional contributions from foundations (particularly the Foundation Consortium on School-Linked Services). Healthy Start funds require a 25 percent local match. This match may be in the form of cash, services, materials, staff, facilities, or other resources.

Each operational grant is limited to three years. Thus, grantees are cautioned to think of Healthy Start funds as "glue" money as opposed to "new" money. The grants cannot be considered as add-on monies or another permanent categorical funding stream.

The legislation allows local collaboratives to use up to 50% of the grant money to purchase services, which they can do through several mechanisms. If this option is chosen, grantees must include in their application how they will wean themselves from this source of money in order to continue the services once the Healthy Start grant is gone. In general, the California Department of Education encourages grantees to think more creatively about how they can use funds currently available and target them more effectively to the needs of their communities.

Data Collection

The Healthy Start initiative has an unusually comprehensive data collection and evaluation component (see section, **Accountability**). Both qualitative and quantitative data are collected from local operational sites. In order to receive Healthy Start funds, grantees must sign a form of commitment to participate in the evaluation and data collection system developed by SRI International (contractor to the California Department of Education).

> *"This cannot be a cookie cutter approach; nor will it work if it is driven from the top down. Healthy Start requires that everything flows from a clear understanding and assessment of local needs. The potential here is dramatic. We are looking at the institutionalization of system change. Healthy Start provides incentive to strategize about ways to better utilize resources currently available."*
>
> Dr. Jane Henderson
> Assistant Superintendent of Public Instruction
> California Department of Education

Unique Features

A unique feature of Healthy Start is that it is not an initiative that "throws money" at the problem. The Healthy Start initiative is broadly focused on looking at more effective ways of meeting the needs of children and families, and creating system change to accomplish this.

State Role

An important aspect of state support for an effort such as California's Healthy Start initiative is the willingness and ability to foster local collaboration and flexibility. Giving grantees the authority to blend funding streams, and then holding them accountable for their decisions, is critical. Providing technical assistance and leadership to help programs accomplish their goals is also crucial. Reinforcing local action with strong commitment from the state level, particularly gubernatorial leadership and commitment, is still another important feature.

The type of commitment and trust required by leaders was demonstrated in California when an "agreement in principle" was signed by Governor Wilson, the State Superintendent of Public Instruction, and the members of the Foundation Consortium on School-Linked Services. This document includes an agreement that the state will "pursue required federal approval and waivers needed to obtain federal financial participation from Medicaid and other programs for state and locally funded school-based, school-linked services." The agreement also states that if the local governance structures (i.e., the school district grantees) become eligible to be Medicaid providers, they will be entitled to receive the associated funds; the money will not go to a state or county general fund or even their school district's general fund. The money will be linked to the provision of more school-based services to children and families.

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Colorado

FAMILY AND CHILDREN'S INITIATIVE

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Colorado

History

In 1987, Colorado's Governor Roy Romer created "First Impressions," an initiative focusing on a child's first five years of life. The creation of this initiative generated awareness and support for children's issues (particularly the significance of early childhood) in Colorado. In 1989, Colorado was one of ten states selected to participate in a Policy Academy on Families and Children at Risk sponsored by the Council of Governors' Policy Advisors (CGPA). Colorado assembled a Policy Academy team that included officials from state government, local government, and the private sector. The Policy Academy team then spent nine months developing a comprehensive strategic plan for families and children at risk.

As a result of the Policy Academy, Governor Romer appointed the Commission on Families and Children in October 1990 to oversee implementation of the strategic plan. Part of the plan included the establishment of Family Centers in eight communities around the state as a way of piloting a new form of local service delivery. The Family Center Project also is intended to initiate many of the system changes that the Policy Academy team believes need to take place in order to make Colorado a more "family friendly" state.

Mission & Goals

The mission of the Family and Children's Initiative is to make major systemic changes to improve the lives of Colorado's children and their families. The Initiative's vision is that, by the year 2000, all children and families will be healthy and productive citizens. The underlying assumption of the vision is that the state "needs healthy and strong families in order to be economically viable."

The stated goal of Colorado's family policy is "to support, strengthen, and promote successful family functioning and to form strong partnerships between families and private and public systems." All policies and programs must provide assurances that they:

- recognize the strength of family ties;
- recognize the diversity of Colorado's families;
- support family stability and unity (cohesion);
- support, not supplant, family functioning; and
- treat families as partners when providing services.

Desired Outcomes

The vision presented in Colorado's strategic plan for families and children identifies four outcome areas, as follows:

- Families and children will have social, emotional, intellectual, mental, and physical well-being to ensure optimum growth and development
- Families and children will live in a nurturing, stable, and safe environment where each individual member's needs are met
- Families and children will have the educational achievement, knowledge, and skills to lead productive and satisfying lives
- Families and children will have employment and income sufficient to meet basic family needs and maintain a reasonable quality of life.

Several specific indicators for each outcome area were established and adopted in January 1991 by the Decade of the Child coalition, a ten-year collaboration that includes the Family and Children's Initiative. The indicators, based on data describing the status of Colorado children and families in 1989 and 1990, are intended to be specific measures of progress by the year 2000 toward achieving the four outcomes.

Family Centers are encouraged to focus their efforts within these outcome areas. Information on all measures are collected in all Family Center communities. However, each Family Center also must stipulate specific outcome indicators for its particular project. Therefore, outcomes differ from center to center depending on the area of focus and needs of the community.

Family and Children's Initiative

Collaboration

State-level collaboration is a high priority in the Family and Children's Initiative, and mechanisms are in place to ensure that it occurs. One mechanism is the Cabinet Council, which represents members of the Governor's Cabinet whose departments directly or indirectly affect families and children. The Cabinet Council has responsibility for supporting the work of the Family Centers by guiding the project through system restructuring, primarily by removing barriers to state funding and service allocation. The Cabinet Council is composed of people who are responsible for implementing system changes and have the authority to redeploy state resources and personnel. In addition to guiding the Family Center project, the Cabinet Council has served as the steering group for the overall restructuring of health and human services in Colorado. In its work at the state level, the Council has developed a collaborative decision-making model which is used in resolving issues that involve two or more agencies.

A second mechanism for collaboration is the Commission on Families and Children. As mentioned earlier, the Commission was established by Governor Romer in 1990 to oversee the implementation of the strategic plan developed by the Policy Academy team. The Commission advises the Governor on the development of policies and positions on families and children, and innovative applications of those policies. Specifically, the Commission:

- provides a crucial link between government and the private sector;
- reviews and evaluates all existing and proposed state policies on families;
- makes recommendations about the Family and Children's Initiative agenda and budget; and
- participates in regional forums to gather input for the strategic plan for families and children and to develop a broad base of public support for the Initiative.

As part of its charge, the Commission advises the Governor on the development and implementation of Family Centers. The members of the Commission are bipartisan and appointed by the Governor. They represent state legislators, local government, child and family advocacy groups, service providers, the private sector, and families that receive services from one or more of the systems serving children and families. In addition, the directors of several state agencies (Departments of Social Services, Institutions, Health, and Education; Governor's Job Training Office; Office of State Planning and Budgeting; and the Colorado Commission on Higher Education) are members of the Commission.

A third mechanism for collaboration is an early childhood "State Efforts Team," established in 1991 for the purpose of increasing communication and building linkages between state health and human services agencies. The group includes representatives from the Colorado Departments of Education, Social Services, Health, and Mental Health; the Governor's Office; and the Office of State Planning and Budgeting. In fall 1992, the State Efforts Team was to develop a formal proposal, to be incorporated into Governor Romer's restructuring plan, that focused on early childhood efforts—particularly the Colorado Preschool project (a state funded preschool program for high-risk four-year-old children) and the Family Center project.

Finally, Colorado was awarded a Head Start Collaboration grant in fall 1992 that has allowed the state to begin working with the federally-funded Head Start programs in Colorado. Head Start was expected to be included in efforts of the Family and Children's Initiative.

State Functions

The state's approach to supporting the Family Center Project of the Family and Children's Initiative is not to be prescriptive or overly specific but rather to provide some guiding principles within which each individual Family Center will determine its own plan of action. The role of the state is to set supportive policy, provide resources, define basic services, set standards, ensure fiscal and programmatic accountability, facilitate local planning, train frontline workers, and supervise and evaluate program effectiveness in the short and long term.

The state provides technical assistance and training through the Family Center Council, which consists of representatives from each of the Family Center sites. The Council meets once every two months to engage in training, technical assistance, and problem solving. The Council also works to identify state or federal regulations that are barriers to local progress. The Family Center Council then provides this information to the Cabinet Council so that the Governor's Office can seek changes in state regulations or federal assistance in removing barriers at the federal level.

Computers have been provided by the state to the Family Centers, enabling the Centers to form a network and have access to the same information system.

Colorado

Membership & Organization

Family Center grants were first awarded in June 1992. Most of the Family Centers are using an existing non-profit or public agency as the lead agency that takes fiscal responsibility for the Family Center grant from the state. However, several Centers plan to become independent, private, non-profit organizations.

Generally, each Center is governed by an executive board or advisory council, but variations exist among the Family Centers. For example, one Center has both entities. The Advisory Council includes high-level local decisionmakers and policymakers who meet quarterly and oversee the Center's operations; the Executive Board has a large representation of parents, youth, and community members. The Board meets monthly, has subcommittees, and oversees day-to-day operations.

In another site, the Center has a council of 12 parents and 11 agency representatives, with the school as the fiscal agent. In a third case, the Center has an advisory board, a youth board, and a parents' board.

Finally, one community views the Family Center as a membership organization where every person who uses the Center can become a member. In fall 1992, this Center was exploring the feasibility of having multiple sites. Each site would have a steering committee comprised of members of the organization (primarily parents but also agency and community representatives). Part of the steering committee's responsibility would be to coordinate input from the membership and develop activities in response to that input.

Decisionmaking

The council or board of each Family Center establishes Center policy and has decisionmaking authority in a number of areas: assessing consumer needs, planning for and implementing direct services, coordinating and integrating services with other agencies, and evaluating outcomes.

Regardless of the form the Center takes (i.e., public, private, or membership organization), most councils or boards hire a formal coordinator for the Family Center or have a lead staff person assume responsibility for certain decisions.

Local Governance Structure

Accountability

Family Centers are held accountable through quarterly reports, site visits, and participation in meetings of the joint Family Center Council. Funds are provided in two installments. If communities are not providing services satisfactorily, funds are withheld until corrections are made. A statewide evaluation of the Family Center project was in the planning stages in fall 1992.

Local Functions

Family Centers are to serve as comprehensive, intensive, integrated, and community-based centers located in or near neighborhood schools. The target population is all families and children who live in "communities at risk" (i.e., those communities with a high incidence of poverty, unemployed or working poor, substance abuse, crime, school dropouts, teen pregnancy, and teen parents). Thus, all families within the community may have access to the Family Center regardless of income status or need.

One function of the Centers is to provide a single point of entry into the health and human services system for families. When a family enters the Family Center, a family advocate works in partnership with them to assess and develop a plan for meeting their goals and needs. Core programs are made available to all families and children. Some families also are eligible for financial assistance through the Center. Another Center function, therefore, is to determine eligibility for such support. Ideally, after assessing a family's needs and determining eligibility for programs and other support, the family advocate will be able to commit the resources necessary to fulfill the family's plan. Ultimately, it is expected that the commitment of resources from the federal, state, and local levels (e.g., existing government funds, local foundation support, business support) will be redeployed at the Family Center level.

Another important function of the Family Center is to offer directly a range of programs and services on site or nearby (see section, **Service Delivery**).

Colorado

Service Delivery

Family Centers are envisioned as pilots for a new form of service delivery in Colorado. Some of the major features of the design include:

- A single case manager for each family
- A single intake or application form
- A form of practice that engages parents and families as equal partners in managing services for the family.

Although information and referral are major functions of the Centers, their goal is to go beyond this to integrate all core services. Family Centers are intended to implement a "one-stop shopping" model that coordinates multiple services located on site or nearby. Each Family Center selects core services to be offered on site and establishes linkages with providers of other services in the area. Family Centers are asked to plan for the following services: (a) early childhood care and education, (b) before- and after-school care for school-age children, (c) mental health, (d) drug and alcohol prevention and/or treatment, (e) delinquency prevention, (f) services to infants and toddlers with special needs, and (g) maternal and child health care.

The family advocate role is key to the successful provision of services at the Family Centers. The responsibilities of the family advocate include:

- Knowing when and how to obtain specialized assistance for the family
- Involving family members in assessing their needs and in defining a plan for improvement
- Having authority to commit resources on the family's behalf
- Following up with the family to ensure that they do not get "lost" between service providers.

Colorado's family advocates typically are "former staff from human service areas who have been re-trained in family-focused, systemic and preventive service strategies." Staff development includes cross-training in "all programs that can support families to ensure that staff have broader knowledge and skills to promote family stability and self-sufficiency." The necessary knowledge base for advocates includes child and family development, parent needs, and systems collaboration.

Funding

Selected Family Center communities receive a six-month planning grant followed by either a one- or two-year implementation grant (depending on the comprehensiveness of their final plan). Implementation grants are one-time, start-up funds intended to help communities develop combined funding streams and enable their Centers to become self-supporting.

Monies for both the planning and implementation grants are pooled funds from corporate contributors; private foundations; the Colorado Departments of Education, Social Services, and Health; the Governor's Job Training Office; Communities for a Drug-Free Colorado; and the Colorado Division of Criminal Justice. The funds contributed by the state agencies are federal funds from the U.S. Departments of Health and Human Services, Justice, Education, and Labor. Communities also pool locally available funding to help finance the Center.

A community-based program called "the Center" in Leadville, Colorado, first used the strategy of pooling funding streams at the local level and now is a model of how such a funding system can operate. "The Center" began in 1988 when a community child care center was created in response to an increase in child neglect and abuse reports—the result of families traveling long distances to available work and leaving children unsupervised. As different local, state, and federal funding streams were tapped, the Center came to offer other services as well. Today, funding comes from such sources as the local school district, Head Start, P.L. 99-457 Part H monies for infants and toddlers with special needs, and the Colorado Preschool project. Communities involved in the Family Center project attend information sessions on blended funding and creative financing strategies, and the Leadville Center model is shared as one way that a community might take this funding approach.

Data Collection

Each Family Center collects demographic and client information. Centers also are responsible for collecting data about the client and program outcomes their communities have chosen. All Centers use a common Family Functioning Instrument and System Change Instrument. Documentation is collected on the implementation process through quarterly reports and site visits.

In fall 1992, the statewide implementation plan included the hiring of an independent evaluator to examine overall outcomes for the Family Center project and determine the benefits of this type of service delivery system.

Data and evaluation information will be shared with those communities who initiate Family Centers in the future.

> *"We are trying to get away from having a lot of categorical programs with their own "pots" of funds and are attempting to look at the broader issues. We haven't been able to capture information on families, let alone treat them together and look at them as a unit. If we truly want to support families, we have to start offering what they need. We have to take off our blinders about what we think families need, and offer what it is that families really do need."*
>
> Claudia Zundel
> Family Center Coordinator
> Office of the Governor

Colorado Learnings

Unique Features

Colorado is trying to build healthy families in a comprehensive, integrated way through its Family and Children's Initiative. To do this the state is "stretching" the categorical boundaries (i.e., rules and regulations) that are currently in place—pushing them outward to see how local communities can operate within the system. Ultimately, the Initiative intends to move toward a system where many of those rules and boundaries are lifted so that localities have maximum flexibility and each Colorado family can be treated as a whole.

Colorado also wants families to not only receive the services that they need but also have a voice in how services are delivered (e.g., via participation on local Family Center advisory boards).

State Role

A state interested in supporting the development and maintenance of local governance structures such as those in Colorado's Family and Children's Initiative needs to take time to build good working relationships between state and local entities. Further, the state needs to encourage widespread public support for the initiative. This process helps alleviate turf issues as well as creates a foundation for institutionalizing changes in the health and human services system.

It is important to have mechanisms at the state level to gather information from the community level. Important information at the local level often never reaches decisionmakers at higher levels. Having a commitment to ongoing information exchange at both levels—state government and the community— provides the mechanism for feedback that can effect change.

Finally, the quality of planning at both the state level and community level is critical. Rather than leaping into the Family and Children's Initiative, much time first was spent in thinking it through and getting the support of all the players. The attitude in Colorado has always been that this effort is a **partnership.**

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Florida

DISTRICT HEALTH AND HUMAN SERVICES BOARDS

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Florida

History

In 1990, one of Governor Lawton Chiles' priorities as a gubernatorial candidate was to establish more community-based, locally-controlled health and human services programs in the state of Florida. Prior to his inauguration in 1991, he appointed the Interim Task Force on Social Services to gather information and make recommendations regarding: (a) unmet human needs in the state, and (b) the organization and delivery of health and human services. After the first task force, other major activities and products followed—including the Health and Rehabilitative Services (HRS) Productivity Enhancement Initiative, the Frederick Commission, the HRS Strategic Plan, and Senate Bill (SB) 2306. Twenty interim planning groups (IPGs), established by SB 2306 and consisting of individuals representing the state's constituents, held public hearings throughout the state. One recommendation from the IPGs was to establish a local structure for the governance of health and human services that would be, to the greatest extent possible, "owned and operated by local citizens." Bob Williams, Secretary of the Department of Health and Rehabilitative Services, developed a 1992 legislative package responding to ideas generated largely by the IPGs.

The resulting legislation, House Bill (HB) 2379, the Health and Rehabilitative Services Reorganization Act of 1992, modified the department's organizational structure and functions by moving planning, budget, and some personnel decisions to district citizens' boards called **health and human services boards**. Since 1975, the state had been divided into 11 regions that functioned as health and human services districts. Beginning with this basic regional structure, HB 2379 created 15 districts, each consisting of one to 11 counties. Four districts are divided into two subdistricts each, and all districts except one have a single health and human services board. The exception—district 11—is made up of two extremely diverse counties, Dade County and Monroe County (the Florida Keys). In this case, each county has its own board. The two subdistricts, however, are required to develop district needs assessments and resource recommendations together.

Mission & Goals

House Bill 2379 articulates the mission of the District Health and Human Services Boards in its six-point rationale for reorganizing the Department of Health and Rehabilitative Services and the statewide service delivery system. One point states "there is a need to create a governance model which allows for a true partnership between the state and local communities and provides for substantial local decisionmaking regarding needs and resources within broad statewide policies."

District boards establish their own bylaws to reflect unique local philosophies or guiding principles. Generally, HB 2379 encourages individuality of board activity within broad policy objectives and the intent of the legislation. Each board is required to work jointly with its respective district administrator—a state employee who is responsible for all HRS service activities in the district's geographic area.

Desired Outcomes

Three types of outcomes are addressed by Florida's District Health and Human Services Boards. First, the outcomes related to HRS services generally remain targets for all district boards. The state defines such services as a set of **core services**, and sets a floor of service delivery below which districts cannot fall. Second, boards will be asked to work with the state on some **statewide goals and priorities** that may require additional services or different modes of service delivery. Finally, an annual agreement between each board and the Secretary of HRS specifies client outcomes and performance measures that respond to **unique needs and goals** identified by the district (see section, **Accountability**). These agreements will reflect local discretion in determining priorities, goals, and service arrangements to meet these goals.

The ultimate outcome of establishing district health and human services boards in Florida is the development of a more efficient and effective service delivery system, as local communities find creative ways to organize and manage services that meet the needs of their residents. The boards and HRS must provide a status report to the Legislature in 1994 on the new system and the board mechanism. The report will include recommendations regarding such issues as district board authority and appropriations.

District Health and Human Services Boards

Collaboration

The organization of the Department of Health and Rehabilitative Services is conducive to collaboration at the state level. HRS is an all-encompassing umbrella agency that includes aging and adult services; children's medical services; health; Medicaid; child support enforcement; alcohol, drug abuse, and mental health; developmental services; economic services; and children, youth, family, and delinquency services.

At the district level, HB 2379 requires collaboration in two ways. First, the process for selecting board members brings people with various local perspectives together around a collaborative mission. Legislation requires that a Nominee Qualifications Review Committee be created in each district through appointments by the Governor, the board of county commissioners, the district school board, the chief judge of the circuit court, and additional selections by the appointed members themselves. The committee reviews all applications for membership to the district board and makes recommendations for appointment, taking into consideration who might best represent their communities' perspectives. Second, district board membership itself is to include representatives from a range of local stakeholder groups who will need to make decisions collaboratively in order to create and implement district plans.

By virtue of membership on a district health and human services board, board members not only make decisions collaboratively but also influence decisions made by their respective departments, organizations, or systems regarding potential interagency collaborations.

State Functions

State-level functions and activities focus on fulfilling Florida's statutory commitment (HB 2379) to reorganize the way health and human services are administered and provided across the state. One vehicle for institutionalizing this commitment is the Statewide Health and Human Services Board, which is composed of the chairs of the district boards or their designees. The board meets at least twice a year, and its function is to advise the Secretary of HRS and make recommendations regarding state action toward improving the effectiveness and efficiency of local service delivery.

HB 2379 requires HRS to provide some administrative relief to district boards by establishing five regional processing centers to handle three functions previously performed by each district: payroll/ leave and attendance, finance and accounting, and purchasing. Processing functions are being transferred to the centers, "to free districts of routine paperwork and allow them to focus more intently on service delivery." Decisionmaking responsibilities in these areas remain at the local level. The first center was operational by the end of February 1993.

The state also provides staffing and other support directly to each district board. District administrators, appointed by the Secretary of HRS, typically are well-qualified professionals with extensive social service or public health backgrounds. Administrators serve as ex-officio, non-voting members of their district boards. Additional staff support for the boards is provided, although in 1992 it was agreed among the Legislature, Governor Chiles, and HRS that such staffing would be accomplished within existing resources. Reimbursement is provided to district board members for costs associated with attending meetings, including travel costs, child care, and other supports necessary to enable consumers and other citizens to participate. After all appointments have been made, HRS gives each board a two-day orientation and training to enable members to fulfill their responsibilities. Finally, technical assistance, historically provided by HRS to districts, continues to be offered regarding such needs as resource acquisition, waivers of state or federal policy, and programmatic decisionmaking. State-level HRS teams began a series of three technical assistance visits to each district in late spring 1993.

Florida

Membership & Organization

House Bill 2379 provides detailed direction regarding the membership of District Health and Human Services Boards. Legislation specifies the total number of members for each district board, the number on each board to be appointed by the Governor and those to be appointed by the board of county commissioners in each member county, eligibility criteria, diversity of membership, terms, and other such requirements. As discussed above, the legislation also is explicit regarding the form and function of district nominee qualifications review committees.

District boards are composed of representatives from local school boards, the private sector and business community, the health care and medical system, judiciary and law enforcement, and consumers (i.e., service recipients and/or their family members). Each county in the district is represented on the board. Boards also have the ability to increase their membership to meet their districts' unique needs for representation.

By the end of February 1993, five Health and Human Services Boards had complete memberships and were legally constituted to begin business. After the initial formation of a district board and establishment of bylaws, the board has discretion over its structure and organization—even to the degree of deciding to change from a district board to subdistrict boards, or vice versa, "if in the judgment of the board, such change is necessary to adequately represent the diversity of the population within the district or subdistrict."

Boards also can appoint standing committees that include members of these same constituencies. Standing committees are not necessarily county-based but rather are programmatic or functional groups dealing with issues (e.g., housing) that cut across all counties and all populations in the district. In addition, boards have the option of appointing ad hoc advisory committees.

The district administrator is granted the authority of an Assistant Secretary by HB 2379. The administrator has essentially the same responsibilities as in the past for directing and coordinating all HRS services in the district, but the authority to establish policies and procedures and to develop an annual budget request is now shared with the district board.

Decisionmaking

House Bill 2379 states that "responsibility and accountability for local human services planning rests with the health and human services boards." At present, the boards do not function as independent entities. They represent a hybrid of an advisory group and a true governing board. Together with their respective district administrators, they have authority over managing and operating service delivery in their districts. They help the administrator set policy in the district and make decisions regarding an array of district activities (see section, **Local Functions**).

Boards cannot hire or fire an administrator, but they play a major role in the process by providing input in their administrator's hiring and evaluation by the Secretary of HRS. District administrators have immediate authority over the expenditure of funds; however, their relationship with the district board is intended to result in collaborative decisions regarding how funds are directed toward service delivery in the district. In the area of personnel, staff provided by the state are directly accountable to the district administrator, not the board; but the intent is for all state staff to be working with the local board.

HB 2379 authorized a three-year pilot project to test budget and personnel flexibility policies that allow district administrators and boards to manage resources to meet immediate and local needs "much like private business has historically done." Personnel management reforms went into effect February 1, 1993; implementation of full budget reforms was to occur by July 1, 1993.

A board may propose to the Secretary of HRS, through its district administrator, the establishment of "an innovation zone for any experimental, pilot, or demonstration project...as a laboratory for the research, development, and testing of the applicability and efficacy of model programs, policy options, and new technologies." A zone can be a county, municipality, school district, or an entire health and human services district. The acceptance of a proposal by the Secretary carries with it his advocacy and assistance in obtaining any necessary waivers to state and federal law.

The authority of the boards will be a major issue when the Legislature hears a report and recommendations from the boards and HRS prior to its 1995 session. At that time, a decision will be made regarding the feasibility of moving the boards to the status of independent governance structures.

Local Governance Structure

Accountability

A Health and Human Services Boards reorganization work group is developing performance measures, outcome measures, and a model for performance agreements that will provide the parameters for district board accountability. The agreement is negotiated between district boards and the Secretary of HRS. It sets forth:

- specific responsibilities of the district (i.e., what the district must do, its expected outcomes, and the nature of local discretion in reaching those outcomes);
- responsibilities of the state (i.e., what the state must do and the specific resources provided by the state); and
- a dispute resolution mechanism (to resolve disputes that might arise between HRS and the board).

The performance agreement is both a working document for the district board and the vehicle through which it is held accountable for service delivery. Among its responsibilities, the board will conduct a local needs assessment—not only for its own use but also to help develop district legislative budget requests. The reorganization work group was drafting such a process in early 1993, and a draft of the dispute resolution procedure was undergoing revision at that time.

Districts are accountable for providing a set of core services determined by the Secretary of HRS (e.g., AFDC and other entitlements) as well as for accomplishing those goals they set forth in their agreement in other more discretionary areas. To measure progress toward outcomes, periodic reports and evaluations of district and board performance are required.

Local Functions

District goals, objectives, and specific board activities are developed jointly by each District Health and Human Services Board and its district administrator. These key functions must be carried out in ways consistent with the statewide policy of providing "a family-centered constellation of services [with the primary goal being] the preservation of families."

Another overarching function of the board is to represent and advocate for the community by assisting in service integration and community resource development, supporting community programs and services, communicating with consumers, and advising the district administrator. Other functions and activities include: (a) determining board organizational structure, (b) electing officers, (c) developing bylaws, (d) conducting needs assessments, (e) developing and approving a district service delivery plan, (f) providing policy oversight, (g) providing budget oversight, and (h) providing input in the selection and annual evaluation of the district administrator.

Ultimately, through representation on the Statewide Health and Human Services Board, district boards will help set state policy, direct priorities, determine how state money is spent, and accomplish statewide data collection.

> "*I think that the desire is to really do a better job, not for ourselves but for the people who we're supposed to help. By having clients and consumers on the board—to say, "Look, I know you think that everything you plan works, and on paper it looks wonderful; but it doesn't work like that when it gets to us"—brings us down to earth. Bringing some of the critical decisionmaking down to the local level and including community leaders and consumers hopefully will keep us a little more grounded than we might otherwise be.*"
>
> Kayce Morton
> Governmental Analyst for
> Planning and Budgeting
> Office of the Governor

Service Delivery

District Health and Human Services Boards are responsible for the service delivery performance of their district. Though services directed by federal policy are not subject to modification, services provided by HRS offices or contracted out to other providers are under the purview of district boards. HRS currently contracts out about 60% of its service budget, with some areas (such as alcohol, drug abuse, and mental health) contracting 75-80% of services.

A district board can review any service contractor, in consultation with the district administrator, and can make changes in contractual arrangements. If a provider's history and performance are good, few changes might be expected. However, with the participation of its administrator, a board can elect to publish a Request for Proposal (RFP) to seek a different provider for any service and solicit an improved proposal from the current provider.

As described earlier, services are selected by district boards to achieve different types of outcomes. All districts will be required to provide a set of core services (under revision by the Health and Human Services Boards reorganization work group in early 1993). Other services that respond to unique local needs and goals will be identified in districts' annual agreements with the Secretary of HRS. New services and implementation strategies can be piloted through the innovation zone option (see section, **Decisionmaking**). Also, districts may offer additional services or develop different modes of service delivery in order to meet statewide goals and priorities, as they develop.

Funding

Resources appropriated by the Legislature are directly allocated to the Department of Health and Rehabilitative Services, then distributed to the Health and Human Services Districts based on various formulas. No changes to these formulas have been made yet; funds were allocated to districts in 1992-93 according to the current distribution. Long-term funding adjustments may be pursued when the boards and their district administrators communicate with HRS and participate in submitting budget requests to the Legislature.

As local communities implement their plans and identify service gaps, they are expected to seek additional resources elsewhere (e.g., local government) to supplement state dollars. Boards cannot independently apply for grants, but HRS will offer information and assistance regarding how to access federal dollars and seek out other sources of funding. Collaboration between localities and the state is intended to "minimize duplication and maximize dollars" on a day-to-day basis.

As with district board authority, funding (equity as well as adequacy of appropriations) will be a major issue when the boards and HRS report to the Legislature and offer recommendations prior to the 1995 legislative session.

Data Collection

Data will be collected in the Health and Human Services Districts through two major types of assessment: needs assessment and annual performance assessment. Ideally, the needs assessment will be as broad as the mission of HRS, addressing the full scope of services and range of populations to be served. District needs assessments will be used by HRS and state decisionmakers in refining the statewide assessment of need. Needs assessment data also will be used by the districts themselves when developing and approving their plans to identify unmet needs and recommend changes in service delivery.

Typical data (e.g., numbers of individuals needing specific types of services) already can be collected by district and compiled statewide via the data systems established in 1976. The challenge now may be how to get data down to the county level. It is anticipated that district boards, rather than helping the state aggregate data (a need among many other states), instead may help the state achieve a level of further detail by providing a breakdown of local data. Decisions to collect any new kinds of data have not been made by the state.

An annual performance assessment of each district will focus on data that measure the accomplishment of societally-based outcomes. This assessment will be a major component of the agreement between each district board and the Secretary of HRS. The data are expected to answer the question, "Did we accomplish anything?"

Districts will have access to current statewide data systems after confidentiality issues have been resolved. For example, the Client Information System enables HRS to track certain kinds of social services (e.g., foster placements, aging and adult services, alcohol and drug abuse services, mental health services). Also, the Division of Management Systems in HRS is coordinating a statewide system that will link AFDC and Medicaid eligibility in one data system. Ultimately, this system will become the operative data system for the entire department—pulling together family, economic, and demographic information necessary to determine client eligibility for all programs. A comprehensive statewide system is expected to enable service providers to access the primary database as they work with families and add information to client files, showing a more complete picture of the services individual families receive.

> *"There is no sense in redoing everything other people have already done. By law we must come up with a single needs-assessment process, and we'll do that. But we'll also utilize what's already there, and we're going to do the needs assessment with existing dollars. I anticipate that local communities will find the resources they need, and that we will find ways within the department to supplement that. Basically, we're trying to build partnerships. We're trying to encourage local communities to begin to own this system. And the best way to do that, we think, is through this process."*
>
> Bill Bentley
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Florida Learnings

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Unique Features

Florida's Health and Rehabilitative Services initiative is unique because it springs from a recognition shared by several disparate groups and agencies that Florida's problems are growing faster than state government can respond. The effort to reorganize HRS and shift authority and responsibility to the local level is based on the belief that the state cannot effectively provide all things to all people, and communities must share and begin to own some of the problems with the state.

The new District Health and Human Service Boards differ from other such bodies established in the past. Their mission is clearly spelled out in legislation, as are their specific responsibilities and expectations. The boards are not advisory groups; they have more influence and more direct decisionmaking power. Furthermore, they may become formal governance structures after the 1995 legislative session. This potential gives the groups status and visibility within the system as full-fledged players and partners rather than advisors. Boards are charged with deliverables: needs assessments, service plans, and input about budget requests and district administrator evaluations. Ultimately, they are accountable for meeting their goals and objectives.

Regionalization (i.e., development and maintenance of a regional or district structure for health and human services delivery) has caused problems in administration, discrepancies in funding, and the emergence of different approaches to service delivery. Regionalization, however, also has allowed the state to incorporate diversity into its planning. It has led decisionmakers to think about different areas of the state more appropriately and limit statewide mandates to certain parameters (i.e., the core services that will be required of all districts).

Finally, the initiative reflects a difference in overall intent and philosophy. The goal is system change, not just service delivery improvement. The bottom-line goal is to create a system that translates into "meaningful, helpful, consistent service to the people needing help who walk in our doors."

State Role

A state must, first and foremost, be "patient with the process" when initiating and supporting local governance structures such as Florida's District Health and Human Services Boards. Working with groups is more difficult than not. There must be a willingness to "go through the stops and starts and squabbles and successes of bringing a group together."

The state role is to plan the best system it can, closely examine how the system functions, and continually ask the question, "How are we doing?" in working toward improved outcomes for service recipients. As problems arise, the state needs to determine where the breakdown is and what can be done to correct it.

A state priority on involving service recipients in providing input and making decisions is also essential; "it is the key to making changes that matter." Their involvement is sometimes uncomfortable for other decisionmaking participants. Clients experience the realities of service delivery problems and gaps, and many will speak bluntly about the disparity between state or local plans and actual implementation.

Iowa

FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM

Iowa

History

Iowa's Governor, Terry Branstad, and the Iowa General Assembly made welfare reform a priority in 1987. Working with the Welfare Reform Interim Committee of the General Assembly, former Senator Charles Bruner developed the first piece of legislation related to family issues in 1987. The Family Development and Self-Sufficiency Demonstration (FaDSS) Program was enacted in 1988, with an appropriation of $690,000 for calendar year 1989. That initiative put into place the Family Development and Self-Sufficiency Council to administer and oversee the program. The composition of the Council, as legislated, includes health and human services recipients, representatives of several state agencies, and university representatives.

Legislation also requires that the reform efforts focus on families at high risk of becoming long-term recipients of AFDC (Aid to Families with Dependent Children) funds. The legislation mandates that funds will flow to the Department of Human Services, but that the department will contract administration of the program to the Department of Human Rights (DHR). DHR is essentially an advocacy agency for basic human rights. This stipulation is symbolic because it communicates the fact that families deserve advocates. The DHR's Division of Community Action Agencies (DCAA) was selected to contract with local FaDSS service providers, due to its experience in administering anti-poverty grants to community-based organizations.

The initial legislation was for a three-year demonstration grant, with money appropriated annually. The initiative has since evolved beyond the demonstration stage and is entering its fifth year of implementation.

Mission & Goals

The mission of the Family Development and Self-Sufficiency Program is to shift the focus of the health and human services system from the individual to the entire family. The initiative was a response to indicators of family distress that were increasingly prevalent. For example, helping individual members of welfare families find employment did not seem sufficient to enable the families to function effectively or end their reliance on AFDC. The basic philosophy behind the program is that comprehensive, capacity-building, early interventions with at-risk families can be successful in improving the stability and self-sufficiency of those families.

The goals of the FaDSS program are twofold. The first goal is to help families obtain self-sufficiency and sustain a nurturing family environment. Assisting families in setting goals for themselves is a major component. Another objective is to search for and eliminate barriers that keep families from reaching self-sufficiency.

The second goal of the program is to keep children out of foster care. FaDSS is considered a pre-crisis family preservation program that maintains a strong focus on parenting education and support groups for parents.

Desired Outcomes

The Family Development and Self-Sufficiency Program is designed to: (1) reduce the number of foster care placements and (2) reduce the number of people receiving Aid to Families with Dependent Children. Results related to the second outcome have been particularly positive. Approximately one-third of the families who have entered the program have ended their dependence on AFDC. Another third are continuing their program involvement. The final third have moved, dropped out, or exited the program for other reasons.

Family Development and Self-Sufficiency Program

Collaboration

The legislation that initiated the Family Development and Self-Sufficiency Program mandates collaboration among the Department of Human Services, Department of Human Rights, and grantees (i.e., community action agencies, county governments, or non-profit organizations). Other entities at the community level, such as local offices of human services and participating schools, also are important partners in collaboration.

At the federal level, there is collaboration with the Federal JOBS Program. Local FaDSS workers, in consultation with FaDSS families, determine when the families are ready to receive employment or training services provided by the JOBS program. The JOBS program contributes financial assistance to FaDSS for JOBS-eligible participants. State administrators and local providers, especially community action agencies, also engage in collaborative planning with the Department of Housing and Urban Development (HUD) and local Public Housing Authorities. Such collaboration resulted in the merger of programs serving public housing residents in several areas of the state.

State Functions

The state provides funding, training, and technical assistance to recipients of Family Development and Self-Sufficiency Program grants. The state-level FaDSS Council reviews local proposals on an annual basis and determines the level of funding for each project. Training is provided to grantees in areas important to building a successful family demonstration program. Grantees have participated in some training sessions or meetings with representatives from other successful programs (e.g., Maryland's Children and Family Services Reform Initiative). In order to provide technical assistance in an ongoing manner, the state created a liaison position to link local grantees with state sources of assistance.

> "*I feel very good about being an advocate for the rights of families. Families **do** have the right to expect education; they **do** have the right to expect respect from other people. Many have surmised that it is the lack of a job and the lack of training and skills that prohibit families from fully functioning. However, it is much more than this. It is a lack of self-esteem.*"
>
> Bette Crumrine
> Program Manager
> Family Development and Self-Sufficiency Program
> Department of Human Rights

Membership & Organization

Family Development and Self-Sufficiency grants are awarded through a statewide competitive process. There are currently 12 FaDSS programs, with a total of 36 sites, housed in three different types of local entities: (a) community action agencies, (b) county governments, and (c) non-profit organizations serving children and youth (e.g., YWCA).

The state has allowed for diversity and flexibility in organizational structure of the FaDSS program. Those programs affiliated with a community-based or non-profit organization are controlled by a voluntary local governing board. Programs affiliated with a public agency have a locally elected governing board. In all cases, boards are responsible for hiring staff as well as managing resources. In most cases, the FaDSS director reports to the director of the home agency, and the agency director is accountable to the local board of directors. Board meetings are held as often as every week and as infrequently as every six weeks.

Decisionmaking

The boards of directors for Family Development and Self-Sufficiency Programs have considerable decisionmaking authority in establishing policy and developing strategic plans for their local programs. FaDSS programs are intended to meet the specific needs of their communities according to a set of parameters established by the state that includes a list of characteristics of potential long term recipients of AFDC. Characteristics include: teenage pregnancy, single female heads of household with four or more children, and recurring episodes of AFDC-eligibility. Local boards use these indicators to target particular populations in designing their programs. Programs also must be designed within the philosophical framework established by the state (i.e., programs should be family centered and flexible).

Local Governance Structure

Accountability

The Department of Human Rights, together with the state-level Family Development and Self-Sufficiency Council, monitors caseload variance and quality of service. Grantees must provide quarterly reports of activities and a monthly financial report. Also, the Council mandates that a state liaison conduct an on-site visit to each site in each FaDSS program once a year.

Based on information gathered from the local programs, a grant review committee makes recommendations for action to the FaDSS Council. There are no special rewards or incentives for programs that achieve their outcomes. However, programs that do not achieve expected outcomes are not re-funded.

Local Functions

The primary function carried out by each Family Development and Self-Sufficiency project is the delivery or contracting of services (see section, **Service Delivery**). Other essential functions include assessing and evaluating local policy, coordinating interagency activity in the community, and collecting and disseminating local data.

Service Delivery

The Family Development and Self-Sufficiency Program attempts to implement a "one-stop shopping" model of service delivery for families. A major service, therefore, is the provision of information to enable clients to identify, locate, and obtain available services in a quick and timely manner.

Some of the direct services that clients gain access to through FaDSS include: in-home case management, child care, family counseling, transportation, parent education, and tutoring. Several projects have on-site capabilities, similar to those in the family center model, that allow staff to conduct group activities with clients. FaDSS staff receive specialized training in family development from the University of Iowa to prepare them to serve clients in this setting.

Funding

The Family Development and Self-Sufficiency Program is a competitive grant program. After the initial grant is awarded, grantees must submit a renewal proposal each year. Basic funding for FaDSS programs is provided through state appropriation, and funds are then allocated to each project by the FaDSS Council.

Funding also is coordinated with the Federal JOBS program, which provides a 50% match of all local monies from state, county, and city. However, these federal funds can only be spent on families eligible for the JOBS program.

Finally, FaDSS programs receive additional funds from local sources such as the United Way, churches, county government, corporations, and individuals.

Data Collection

Survey research has been conducted with Family Development and Self-Sufficiency Program participants. One such study compared FaDSS families with a control group of similar families who had not received family development services. A comparison was made between the two groups by examining differences in the types of jobs the adults acquired. The findings indicated, for example, that once individuals had participated in family development, they were more conscious of benefit packages. It was found that FaDSS participants were not as likely as individuals in the control group to accept jobs that didn't have health benefits.

Other data collected in September 1990, based on 360 families from eight different project sites, yielded the following characteristics of FaDSS families: (a) 25% were victims of physical abuse, (b) 26% were victims of sexual abuse or incest, (c) 40% were children of alcoholics, and (d) 25% were current victims of domestic violence. Results of this study are significant; they confirm the belief that there are often other needs that must be met before people can successfully seek gainful employment.

Other data collected by grantees include client characteristics (e.g., age, gender, race, disability), specific services provided, and number of clients served. Statistics based on these data are compiled and used in several different ways, including for funding purposes. A large-scale, independent evaluation will be completed and released in 1993.

Unique Features

An important feature of the Family Development and Self-Sufficiency Program is its focus on the family rather than the individual. The FaDSS program even works with "significant others" (i.e., anyone living under the same roof with a family) as members of the family. Setting goals for and working with the family as a unit are emphasized.

Another important feature is the mechanism for controlling caseload size. As stated earlier, due to the intensity of the program, the Department of Human Rights and the state-level FaDSS Council together monitor caseload variance and quality of service. This mechanism provides the time that workers need to go into homes and establish relationships with their client families. It also provides them the time and flexibility to address the variety of needs that families experience.

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State Role

A state can best support an initiative such as Iowa's Family Development and Self-Sufficiency Program by providing information and assistance in the areas that are key to local success, such as interagency collaboration and client and family tracking.

Developing and implementing an evaluation component is critical. Some form of measurement is helpful as a feedback mechanism to local programs as well as a tool for making state-level decisions.

It is also vital that the state is respectful and supportive of local priorities, just as providers must be respectful and supportive of families. These parallel processes of support help make the program successful.

Kentucky

FAMILY RESOURCE CENTERS AND YOUTH SERVICES CENTERS

BEST COPY AVAILABLE

Kentucky

History

In November 1985, a group of 66 Kentucky school districts formed the Council for Better Education and filed a lawsuit challenging the equity and adequacy of state funds for education. In October 1988, the Franklin Circuit Court ruled in the council's favor, declaring **not** that the state's education finance system was **inequitable** but rather **inefficient** (the state constitution requires an "efficient system of common schools"). The state General Assembly appealed, creating the court case now known as *Council for Better Education vs. Rose*. In June 1989, the Kentucky Supreme Court ruled on the appeal, and its judgment went well beyond the fiscal inefficiency charged by the lower court. The high court ruled that all statutes related to education were unconstitutional in that none created the required efficient system of common schools. The Supreme Court also explicitly declared that the education system was the responsibility of the General Assembly.

A Task Force on Education Reform was created in July 1989 to provide recommendations to the General Assembly. It consisted of sixteen members of the House and Senate (including the chairmen of the Senate and House Education Committees) and five appointees of former Governor Wallace G. Wilkinson. The co-chairs were Speaker Donald J. Blandford and Senator John A. "Eck" Rose (President Pro Tem). Three committees on curriculum, governance, and finance, formed by the Task Force, worked to develop concepts and proposals for consideration. A final report was adopted in March 1990, and the General Assembly incorporated this work and a funding plan into House Bill 940 (HB 940, the Kentucky Education Reform Act of 1990), which passed in April 1990 and became law in July 1990.

The decision to establish Family Resource and Youth Services Centers (hereafter referred to as Centers) in schools was a response to a number of needs identified as the General Assembly worked on HB 940 (see section, **Mission & Goals**). HB 940 outlined the concept and the legal intent of the Centers, and established an Interagency Task Force on Family Resource and Youth Services Centers to develop a five-year plan for the voluntary creation and implementation of Centers at school sites. It is anticipated that, within four to five years, all schools that are eligible will have a Center.

Mission & Goals

A number of related needs merged to create the mission behind Family Resource and Youth Services Centers. First, the Kentucky Supreme Court 1989 ruling on *Council for Better Education vs. Rose* defined an "adequate education" as one that develops seven specific capacities in children. These seven capacities form the framework for the new educational system created in HB 940. One of the capacities is "sufficient self-knowledge and knowledge of one's mental and physical wellness." This capacity creates a direct linkage between a child's mental and physical health and his or her education.

Second, the Council on School Performance Standards (established in early 1989 by former Governor Wilkinson) had produced a set of learning goals, outcomes, and assessments appropriate to the needs of students into the 21st century. These goals include two associated with physical, mental, and emotional well-being: (1) demonstrates self-sufficiency, and (2) demonstrates responsible group membership. The valued outcomes related to these goals address children's needs for physical and mental health knowledge.

Third, HB 940 includes a statement regarding the need for the educational system to "reduce the physical and mental barriers to learning." Finally, some key legislators were from major metropolitan areas where the concerns of low-income constituents were a high priority.

All of these forces converged to create a consensus on the need for schools to deal with emotional, health, or other non-academic problems that might affect children's learning. A school-based Center concept was selected as the way to address this need.

The stated mission of the Centers is "to promote the flow of resources and support to families in ways to strengthen the functioning and enhance the growth and development of the individual members and the family unit." An elementary school in which 20% or more of the student body are eligible for free school meals can apply to establish a Family Resource Center on or near the school site. A middle or high school that meets the same criterion can establish a Youth Services Center. The Centers are a mechanism for ensuring that services are available to children (and their families) in order to help them achieve learning outcomes and to assist the schools in achieving related system outcomes. In any Center funded by the state, **all** children in the school are eligible for services from the Center.

Desired Outcomes

The ultimate outcome intended through the establishment and operation of Family Resource and Youth Services Centers is the reduction of physical and mental barriers to learning.

Collaboration

Kentucky's Family Resource and Youth Services Centers are funded through the Department of Education, but the Cabinet of Human Resources (the agency that houses all human services departments) administers the programs. This collaborative relationship enables the Centers, though located at schools, to tap into any agency, service, or program under the purview of the Cabinet of Human Resources (CHR). The Cabinet has obtained additional federal dollars for small research activities and training of Center coordinators or other Center staff. A two-year grant from the Mott Foundation sends Center coordinators to Flint, Michigan, for a week of training in how to work with a community. A grant from the Pew Foundation is designated for implementation research and training.

Mandated collaboration between the Department of Education and CHR at the state level has encouraged and facilitated collaboration at the local level between schools or districts and social service agencies. Some Centers also are working with regional mental health centers that are funded through other governmental programs, either state or federal.

State Functions

The Interagency Task Force on Family Resource and Youth Services Centers will continue to function until December 31, 1995. Its primary function is to develop a statewide network of Centers in schools and districts. Specific responsibilities include: reviewing district grant applications and recommending awards to the Secretary of the Cabinet of Human Resources, monitoring progress, revising the implementation plan as needed, and making an annual report and recommendations to the Secretary of CHR and the Governor.

Task Force members review district grant applications based on input from a panel of 40-50 volunteers representing public and private service providers, community action groups, higher education, and other stakeholders. This process effectively removes the awarding of Center grants from the political process and local favoritism.

Major functions of CHR include: coordinating the state-level program and policy, creating administrative regulations that establish criteria for awarding district grants, and providing consultation and technical assistance to districts and Centers. The Cabinet also performs the following administrative functions: (a) develops (and revises as needed) a common parental consent form for Center use, (b) facilitates information sharing within the network, (c) awards district grants through contracts, (d) arranges for Center staff training, (e) compiles statewide data, (f) monitors Center activities, (g) facilitates the development of new funding opportunities, and (h) arranges for Interagency Task Force meetings. CHR also assists the network of Centers by maintaining relationships with national and other state organizations or programs, and holding an annual conference to showcase exemplary programs and disseminate materials.

State-level decisionmakers demonstrate commitment to the success of the Centers, sometimes simply through communicating the expectation that all state and local people should demonstrate the same commitment. For example, the Secretary of CHR sent a letter to all local human services employees emphasizing their role in the schools and stating the expectation that they would participate in the Center initiative by serving on a local advisory council if asked.

Kentucky

Membership & Organization

At the state level, the Interagency Task Force on Family Resource and Youth Services Centers was first chaired by the Secretary of CHR, Dr. Harry J. Cowherd. The Task Force consists of 16 members representing each of the following departments or cabinets: education, employment services, health services, mental health and mental retardation, social services, social insurance, work force development (i.e., adult and vocational education), and justice. The remainder of the members are representatives from local community action agencies, local health departments, and other entities specified in statute. This task force created a basic framework for the structure and management of the Centers. The framework includes broad guidelines for the establishment of a local advisory council, but there is the implicit assumption that there is no model Center. A Center is intended to reflect the needs and characteristics of the school population, the community population, and the advisory council at that particular location.

At the local level, schools or districts that apply for a Family Resource and Youth Services Center grant may have a local advisory body of any size, but one third of the members must be parents of students in the eligible school(s). These parents must be strictly parent representatives, that is, not a teacher in the school who is a parent, or a local health department employee who is a parent. Also, parent membership must reflect the socioeconomic and racial diversity of the community. Youth Service Centers serving middle or high school students should have two student representatives. Beyond this, local advisory councils include school staff members who are representative of the faculty and staff. It is suggested that schools with special programs (e.g., dropout prevention, community education, Parent and Child Education, drug education) include representatives from those programs. Finally, the community at large should be represented, including any local, public or private service providers (e.g., health department, mental health-mental retardation center, local CHR offices, community action agency, child day care providers, justice system) as well as other community members interested in education.

To ensure broad representation of all stakeholders on the local advisory council, a community can establish a number of subgroups whose leadership are members of the advisory council.

Decisionmaking

The school or district's local advisory council is responsible for decisions related to preparing its application for funds from the state to establish and manage a Family Resource or Youth Services Center. The local application for funding is to include a plan outlining a program model developed by the advisory council, based on the results of a community planning process that accomplishes three tasks:

- Inventories current services available in the local area to support families
- Assesses "less formal community-based organizations and resources" that could participate in service provision
- Identifies unmet needs and gaps in supports and services for children, youth, and families.

The plan describes how the Center will be organized, its goals and objectives (which differ between Family Resource Centers and Youth Service Centers), and the services to be provided by or accessed through the Center.

The advisory council establishes job duties and identifies necessary skills and abilities of Center staff, based on the specific nature of the Center's planned services and activities. The Interagency Task Force's State Implementation Plan states that, "The expectation is that at a minimum a Center will have a full-time staff member [i.e., Center coordinator]....who is responsible for the oversight of the program. There is no presumption that other staff would be full-time nor that they would be employees of the Center. Innovative collaborative staffing patterns are encouraged and in fact will maximize the impact of a Center." Center staff are employees of the school system so, though the local council recommends staff to the superintendent, he/she does the actual hiring. Thus far, it appears that superintendents are fully accepting council recommendations.

Once funded by the state, the Center's resources flow through the local school board; but the board cannot change the advisory council's plan for Center services and activities.

The advisory council assists Center staff with the development of procedures for obtaining parental consent, communicating information about Center services to parents and guardians, and conducting effective outreach to parents. Such procedures include making arrangements with the school district to ensure that Center services and activities are available "on days and at times which offer the maximum accessibility for parents, children, and families."

Accountability

Each local advisory council develops an evaluation plan in its initial Family Resource or Youth Services Center proposal. Evaluation guidelines are general, though the State Implementation Plan offers specific ideas for the types of formative and summative evaluation that Centers might use. If the state, in reviewing the plan, finds a mismatch between goals and the evaluation plan, technical assistance is provided. Evaluation of the Center's program is conducted by the local advisory council, and the results are incorporated in the following year's application for continued funding. Approximately twelve staff from CHR are available to provide on-site technical assistance. Centers whose evaluations indicated difficulties in 1991-92 were focused on by staff during 1992-93. It is anticipated that funding in the future will be automatic unless a Center clearly is not meeting its goals.

The state's general approach to accountability is to support the Centers and provide the assistance necessary to enable them to be successful. There is a sensitivity to the fact that Center goals are not static. They may change over time, and may even require refinement during a single implementation year.

The state also recognizes that outcomes that are easily supported (e.g., by numbers served) may be weak or incomplete measures of performance during the early years of Center operation. For example, the number of pregnant students served by a Center is an easily measured outcome; but one Center coordinator believes that the young women served in his Center benefited in specific ways that can be measured only over time. Compared to past years (when no records were kept), he believes the young women served by the Center last year stayed in school longer before the birth of their children, and returned to school earlier. Also, all probably received earlier and more consistent prenatal health care, which can be expected (but not yet proven) to have a positive impact on their children's health and on their own postpartum health.

Local Functions

The major functions of the local advisory council are related to the determination, planning, and management of its Family Resource or Youth Services Center. A council also can collect information, conduct local surveys, set up communication networks, and engage in other activities that support the Center's functions.

A basic premise behind the Family Resource and Youth Services Centers is that most of the services children and families need exist in their communities or local areas, but lack coordination. There has been no link forged between local service providers and schools, yet the school may be the single most familiar place to children and adults in a community. Parents may be more willing to come to school than many other places where services might be offered. Even those parents who have had bad experiences in school may feel it is a natural place to go to get assistance for their children's needs--whether educational or health or other.

Based on this assumption, the Centers' major function is to "promote identification and coordination of existing resources" for children and families. This function is grounded in a set of four shared principles and values about families and children and the types of assistance that are most useful to them. The following principles were set forth by the Curriculum Committee of the Task Force on Education Reform, which emphasized them as fundamental to the development of the Centers:

1. All children can learn, and most at high levels
2. Create an atmosphere that empowers the participant (consumer) to acquire the competencies necessary to meet the needs and achieve the goals of attaining an education
3. Develop an interagency focus
4. Assure community ownership.

Service Delivery

Family Resource and Youth Services Centers are not intended to be places where people go for direct services, though direct service delivery is possible. For example, some Centers offer meetings for groups of parents to deal with particular issues or provide mutual support. The assumption, again, is that many of the direct services needed by children and families are available in the local area, but service coordination and access are not.

The primary service of all Centers is referral and follow-up. Section 18 of HB 940 specified a number of core service components to be addressed by each Center. A family case management approach is generally used to address these components. This approach involves not only the appropriate identification of what a specific child or family needs, but also the identification of what the school and Center need to do in order to build and maintain working relationships with all the agencies whose services they must access.

The core service components that Family Resource Centers at the elementary school level must address include:

- Full-time preschool child care for children two and three years of age
- After-school care for children ages four through twelve, with the child care being full-time during the summer and on other days when school is not in session
- Families in training, which shall consist of an integrated approach to home visits, group meetings and monitoring child development for new and expectant parents
- Parent and child education (PACE)
- Support and training for child day care providers
- Health services or referral to health services, or both.

Youth Services Centers must address the following components:

- Referrals to health and social services
- Employment counseling, training, and placement
- Summer and part-time job development
- Drug and alcohol abuse counseling
- Family crisis and mental health counseling.

Those Centers that offer a meeting place for parents focus on a range of topics from children and alcohol, to helping a child obtain job training or skills, to how to stop smoking.

Funding

Family Resource and Youth Services Centers are funded at a maximum of $90,000, with a minimum set at $10,000 to ensure that a Center in a small school can hire at least a part-time staff member to coordinate the effort. In 1992-93, the average grant was $72,000. The only base requirement is that 20% or more of the school's student population must be children in low-income families, as indicated by their qualification for the free lunch program. The dollar amount awarded to a Center is determined by a formula based on the number of low income children who attend the school(s) to be served by the Center. The result in the first year of operation was a little more than $200 per low-income child per Center. Though it is the number of low-income children that generates the funding amount, the Center's services are available to all children in the school(s) it serves.

The maximum funding level set by the state is not only a function of the state's fiscal limitations, but also a motivator for local communities and state-funded service providers to collaborate. Local advisory boards are encouraged to look for other sources of resources. Most are finding these sources among private service providers. In the metropolitan areas in particular, health care agencies, hospitals, and similar institutions are donating considerable amounts of either time or services. Universities are gradually providing some services, most notably the University of Kentucky and the University of Louisville. Medical schools and schools of social work are becoming interested in providing support groups and conducting school visits on a periodic basis. In all areas, local businesses, churches, and community groups are depended on for assistance.

Centers are asked to report on other sources of revenue receiving during the year, including in-kind contributions. School boards are expected to pay basic indirect costs not paid by the state grant but related to the Center's operation (e.g., utilities, custodial services). If the school board contributes any additional funds, these also are to be reported by the Center.

Data Collection

Each Family Resource and Youth Services Center is built on a different set of local needs. However, some common data are collected relative to the number of contacts and services provided or accessed. Such indicators, for example, include the number of children referred to state agencies, or number of children in child-care programs before school.

The Cabinet of Human Resources is charged with compiling statewide data on "process, services, and performance outcomes through a statewide reporting and evaluation system." Data collected from the Centers will supplement data obtained through other sources. One of the major uses of the data will be to determine whether the state needs to allocate more resources for CHR to distribute to the local level. Center data will provide direct evidence of how well the services available in their communities match the needs of the children and families they refer.

Another state use of data will be to create an accurate profile of Kentucky's children. For example, the type of referrals made in different parts of the state can be used to help compare the life conditions of children and communities throughout the state. It is expected that these kinds of comparisons will allow the state to determine whether it needs to redirect some programs, reassess how it is providing a particular service, or provide a new service in a particular locality.

Finally, CHR intends to communicate locally-specific data back to the community. There, the data can be used for planning purposes, from a preventative standpoint as much as to meet current needs. For example, a large number of referrals for a particular service among children in late elementary years can indicate that the Center should examine the need for a related service to younger children, or to their families, to reduce or eliminate the need for more intensive services in their later years.

> *"In all honesty, a lot of these "new" ideas that Kentucky put in the reform act are nothing more than common sense. Teachers have always said that if a child was up all night because of problems at home, or she's got health problems, or her mother and father are going through a divorce—all of that prevents her from doing well in school. What's been needed is a process and somebody to say, "let's develop a plan to address this so that we can get on at school with educating children."*
>
> Tom Willis
> Legislative Fiscal Analyst
> Legislative Research Commission

Unique features

The Kentucky Education Reform Act of 1990 has changed how the state does business with educating children; removing the physical and mental barriers to learning is an integral component in ensuring the success of the reform. The implementation of Family Resource and Youth Services Centers is intended to change how the state provides access to the social services that children and families need in order to benefit fully from educational services. The Centers provide a mechanism for directly linking people with the services that already exist but have been merely available—not accessible—to many families.

The Centers also are organized to tap into potential community resources. Center staff find many people in the community want to help in various ways; they "just need somebody to make the contact."

Centers focus on community-specific needs. In this way, local problems can be addressed by redirecting the particular school system or local service delivery or both. It's only if there is "a common problem across the state that you address it with a broad brush."

State leadership believes that a school-based Center approach enables the state and local communities to serve children better than they ever have. Leaders, however, accept the fact that "we won't know for another 5, 6, 7 or 8 years, if we have to look at hard data." Feedback from teachers and principals has been positive, and more one-to-one contact with parents is being achieved. More personal home visits are taking place with a wide range of parents, from expectant mothers to those who just need "someone to be there with them" as they deal with a multitude of problems.

Finally, school-based centers are not uncommon around the nation, but in some places the focus is on making a big difference for only a few. For example, in Baltimore there are two such centers that are funded at half a million dollars each, which can be interpreted to mean "they are doing a great thing with 1% of the children in the system." In Kentucky, 133 Centers were established in the first year (1991-92). In 1992-93, 73 additional Centers were funded—making a total of 206 Centers serving 393 of the state's eligible schools. Some people think that, eventually, every school in the state will have a Center—regardless of the socioeconomic status of its students.

State Role

The state role in initiating and supporting local governance structures for health and human services (such as those associated with Kentucky's Family Resource and Youth Services Centers) is much the same as it should be in restructuring the educational system. The Kentucky Education Reform Act of 1990 mandated that schools have site-based councils based on the belief that, within a broad state framework, parents and teachers can and should make decisions on how to best educate the children in their particular school. The same approach is needed in providing health and other social service needs. A local group consisting of parents, service providers, and other stakeholders needs to sit down and work out together how they are going to get services to the children in their community. The state needs to set broad guidelines but not dictate what the Centers will look like, what the mix of services will be, or how those services will reach the children and families who need them.

The state also must expect and encourage variations among Centers because, "What works in the big town of Taylorsville might not work five miles down the road."

Finally, the state needs to provide local advisory councils and their Centers the opportunity to make alternations—changing methods, adding and deleting services as needed, "simply making those changes and moving on."

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Maryland

CHILDREN AND FAMILY SERVICES REFORM INITIATIVE

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Maryland

History

Maryland had been engaged in interagency coordination long before the implementation of its Children and Family Services Reform Initiative. Nearly 10 years ago, the Annie E. Casey Foundation awarded the state a five-year grant for $7.5 million to evolve from a cooperative arrangement among state departments to a collaborative one. In addition, the foundation, with assistance from the Center for the Study of Social Policy, provided components of a conceptual framework to begin the process of reforming programs, decisionmaking, and fiscal strategies. To help develop the state's interagency capacity to care for children and families, Governor William Donald Schaefer appointed a special Secretary for the Office of Children, Youth, and Families.

The creation of the Children and Family Services Reform Initiative was one result of these coordination efforts. The first cycle of the continual planning process for the Initiative took place from the end of 1988 through mid-1989. Maryland began serving families under the new reform principles in June 1989. In 1990, the state General Assembly adopted Senate Bill 389, which "strengthens the Office for Children, Youth, and Families in order to coordinate family and children's services and requires local jurisdictions to establish local planning entities to develop a local interagency service system."

Mission & Goals

The intent of the Children and Family Services Reform Initiative is to restructure the human services delivery system, developing a seamless system of support that responds to families' needs in a timely way and takes the system itself "from fragmentation to collaboration and comprehensive interagency planning."

As formulated by the Governor's Subcabinet for Children, Youth and Families, the mission of the Initiative is:

> to promote a stable, safe, healthy environment for children and families, thereby increasing self-sufficiency and family preservation. This requires a comprehensive, coordinated interagency approach to provide a continuum of care that is family and child oriented and emphasizes prevention, early intervention, and community-based services. Priority shall be given to children and families most at risk.

The long-term goals of the Initiative are to: (a) provide better, family-focused services to children who are presently in or at risk of out-of-home or out-of-state placement, and (b) begin to redirect funding streams and fiscal incentives away from inappropriate out-of-home placements and toward community-based services.

In 1989, a demonstration of interagency, family-focused service was established in Prince George's County. Two years later, the state released a Request for Proposal (RFP) for the creation of local family preservation demonstration sites in other counties across Maryland. The goals of these initiatives were: (a) to establish a local interagency planning, implementation and monitoring entity for the local provision of services; (b) to reduce the number of out-of-state placements; (c) to prevent inappropriate out-of-home placements on an interagency basis; and (d) to redirect funding streams and incentives from out-of-home placements to community-based services.

Desired Outcomes

The Children and Family Services Reform Initiative intends to achieve three primary long-term outcomes. The first is a fundamental change in the way decisions are made about services to families and in the roles of the state and local jurisdictions in decisionmaking. The Governor's Subcabinet for Children, Youth, and Families is attempting to shift the role of the state to one of setting guidelines and parameters, allocating pooled resources to the local level, and moni-oring and evaluating programs. Local governing boards make decisions related to developing the local service system, allocating resources at the local level, and setting outcomes.

The second desired outcome of the Initiative is a change in the funding mechanisms that support families. This is accomplished by pooling funding streams from the various agencies and allocating them to local governing boards to be used flexibly at the local level. This process gives family workers the authority to spend dollars to meet families' needs. Maryland also attempts to maximize federal funding by redirecting savings back to community-based efforts to support families. Such redirection of funds is a fiscal incentive strategy involving state as well as federal monies. For example, if a local governing board can provide support to families more cost-effectively at the local level than the state has done, the board is allowed to keep as much as 65-75% of the savings to redirect into the development of community services. The remaining 25-35% of funds generated by savings in out-of-state or out-of-home placement costs are used by the Governor's Subcabinet to develop community-based services based on state priorities.

The third, and perhaps most vital, outcome of the Initiative is the implementation of a new service-provision model—one that focuses on the family as a unit in such a way that the entire family becomes the client. To achieve this outcome, workers use a family partnership approach. The family is a full partner in making decisions about how supports are developed for its members. A **single** case manager or family worker develops a relationship with a family that allows him or her to do therapeutic intervention and serve as a role model. Most importantly, the family worker supports the family's efforts to move toward self-sufficiency.

Children and Family Services Reform Initiative

Collaboration

The Children and Family Services Reform Initiative resides within the Office for Children, Youth, and Families. The Governor's Subcabinet for Children, Youth, and Families oversees the implementation of local programs. During the 1993 legislative session, the General Assembly placed the Governor's Subcabinet in statute as the structure within the state where collaboration among agencies takes place formally. Collaboration occurs on an informal basis as well. For example, the Office for Children, Youth, and Families works closely with the advocacy, academic, and service provider communities to set a state agenda for children.

Planning and marketing also take place at the state level. These are two activities that have been very important to the success of the Initiative. A team of people at the state level is responsible for policy and planning related to the Children and Family Services Reform Initiative. Most of the team members are from various public agencies such as Child Welfare, Medicaid, and Juvenile Justice. There are currently 10 team members who have been redeployed from these agencies; serving on the team is now their sole job. This team of people serves a critical role in developing policy and also in educating the public and the legislative, judicial, and executive branches.

Thus far, collaboration with federal agencies takes place on a limited basis. Staff members working with the Initiative work closely with the Center for the Study of Social Policy in Washington, D.C. The Center works with other organizations and the federal government on behalf of children and families. Also, because Maryland was one of the first states to restructure its system, staff members working with the Initiative have had the opportunity to serve as consultants to the federal government as well as to other states.

State Functions

The state has devised guidelines for the development of local systems of care under the auspices of the Children and Family Services Reform Initiative. State guidelines set clear expectations regarding membership of local governing boards, scope of authority, responsibilities, and target populations for the program. Local governing boards must write a proposal explaining how state dollars will be used to implement a local family preservation initiative in their jurisdiction. An interagency team evaluates all proposals and makes a recommendation to the Governor's Subcabinet for Children, Youth, and Families for funding.

In developing a statewide accountability system, state decisionmakers have struggled to find a balance between local authority and state prescription. They also chose to focus more on program-related outcomes than on budget-oriented outcomes. They established a system in which local governing boards develop their own outcomes, conduct their own trend analyses, and, based on the trend analyses, set quantitative goals for what they expect to accomplish in a year. The Governor's Subcabinet conducts an annual performance review of each local initiative based on the goals and objectives set by its board.

The state provides start-up money to governing boards for local planning activities, and training to meet the needs of individual boards. The state also provides training support to local staff on planning and service provision techniques. For example, training is provided on elements of the Homebuilder's program (a model for intensive family preservation implemented in the state of Washington since 1974). In 1991, four conferences were held to teach staff how to develop plans for providing Wrap-Around Care, which is a service delivery model that emphasizes individualized, child and family centered care and planning.

Membership & Organization

When a city or county forms a local governing board for its Children and Family Services Reform Initiative, it selects an organizational structure appropriate to its needs. The board may become either a unit of county government, or a quasi-public, non-profit organization. Each structure has its own benefits and drawbacks. As an arm of local government, a local governing board enjoys the benefit of various kinds of support; however, it can be restrictive in terms of exercising an advocacy role. The quasi-public structure offers a great deal of freedom from government regulation, which has tremendous advantages; however, there may be a more limited scope of authority and power.

Each jurisdiction (i.e., city or county) is led by either a mayor, a county executive, or a set of county commissioners (referred to as chief executive officers). These persons appoint the local governing board members. Boards must include representatives from the Departments of Human Resources, Juvenile Services, Health, and Mental Hygiene; the local school system; and local government. Fifty-one percent of the board's membership must be from the private sector, which includes private providers, consumers, and the business community. Judiciary and law enforcement representation is also encouraged.

Board leadership has developed very differently among the jurisdictions. In some cases all of the executive offices are filled by people from the private sector, and in other cases they are filled mostly by representatives from local government.

In addition to executive officers (i.e., president and vice president), each governing board has a staff consisting of a director, a fiscal officer, and an administrative support person. The director oversees most of the activities of the governing board.

Decisionmaking

The local governing boards of the Children and Family Services Reform Initiative exist in law and in light of their appointment by county government. Currently they have the authority and responsibility for planning and developing a state-funded interagency system of support for families, allocating resources, providing oversight, and monitoring the local system of support. Parameters and guidelines are set by the Governor's Subcabinet for Children, Youth, and Families.

The governing board is responsible for developing a local proposal for the provision of family preservation services throughout the entire city or county. In order to develop this plan, the board must examine and assess the current state of family preservation services in the local jurisdiction. Such an assessment includes which agencies are delivering services and how, who is receiving them, and where needs are unmet. Based on this assessment, the board develops community strategies to address unmet needs and outlines plans for service delivery, resource allocation, and outcome monitoring. During the first year of operation, the chief executive officer of the jurisdiction submits the local proposal. Thereafter, once the governing board is established, the proposal is submitted to the Governor's Subcabinet by the governing board.

At this writing, the Office for Children,Youth, and Families is working on further articulating the scope of authority and responsibility of local governing boards.

Accountability

When reapplying for state support, local governing boards must include a report of their outcomes achieved under the Children and Family Services Reform Initiative. They also submit quarterly reports of progress on quantitative measures, which address questions such as: Did you serve the number of families that you intended to serve? Was there a decrease in the number of children going into placement? Each local governing board also must develop a set of qualitative measures to address such questions as: What are the differences in families' lives? What is the impact on the community? In this way, boards engage in a self-evaluation process.

The Initiative has developed a management information software package tailored to the specific data needs of local boards. This package allows local governing boards to answer such questions as: Are we serving the families we intended to serve? Are we using the models we intended to use? The software package provides an automated case record which can produce reports that address these questions. The software allows supervisors and/or workers to query the data according to local needs. Managers can aggregate data across sites to create a statewide picture of the differences among jurisdictions (e.g., rural versus urban). The software has a self-evaluating function that can provide data at any time, saving the costly expense of engaging an independent evaluator. This self-evaluation feature enhances the local boards' capacity to monitor their own systems.

If local governing boards meet or exceed their outcomes, they earn financial rewards (i.e., additional discretionary money). Incentives are only available if local boards demonstrate cost-effectiveness in meeting outcomes. If outcomes are not met, there is a deduction from the total incentive pool that is based on how far away they are from meeting their anticipated outcome.

Local Functions

Under the Children and Family Services Reform Initiative, the primary function of the local governing board is to develop a collaborative process at the local level for creating a seamless system of support. This function gives the board responsibility to make all local policy decisions, fiscal decisions, and program decisions within the parameters that have been set by the Governor's Subcabinet for Children, Youth, and Families.

As it relates to interagency activities, the role of the local board parallels the role of the Governor's Subcabinet. That is, each board is responsible for initiating and coordinating all interagency activities in its jurisdiction.

Service Delivery

Local governing boards of the Children and Family Services Reform Initiative are responsible for delivering a set of core services in their city or county. One such service is case management for intensive family preservation services. Another is case management for children returned and diverted from out-of-home and out-of-state placements. Boards have the option of contracting for core services or delivering these services directly.

Other services are selected by the boards to meet special needs in their jurisdictions. For example, some local governing boards are implementing P.L. 99-457, the Infant and Toddler program. In other cases, boards have taken responsibility for the comprehensive mental health services plan. One local initiative provides in-house mental health services and substance abuse services. Others contract for advocacy services and respite care.

Funding

At present, no federal funds flow through the Children and Family Services Reform Initiative to local governing boards, although plans are being made to reinvest maximized federal dollars. Local boards depend on a mix of monies from many sources, including general funds and funds for state placement, foster care, community placement, non-public tuition, mental health residential treatment, and detention.

Foundation money is used primarily for one-time-only costs, although some also has been used for developing the information system and for training. Using foundation money to invest in services is avoided because it becomes very difficult to continue the services when such funds are depleted.

No specific local matching requirement exists, although some investment is required. Such investment may be cash contributions, telephone service, office furniture, or secretarial support. Local governing boards that are established as non-profit organizations have the opportunity to sponsor private fundraising.

Funds are allocated to local governing boards on the basis of the number of families they are going to serve and type of referral sources to be utilized. For example, monies that would pay for a child's placement in a mental health treatment facility can be redirected to the local governing board. The cost of placing a child in a treatment facility is about $38,000. If a local governing board determines that it can prevent the referral and placement of 10 children in mental health facilities, then it will receive $380,000 from that state budget. Local budgets, therefore, are based on the number of children targeted for service, and the dollars that the state would have spent in the absence of the local initiative. This funding mechanism has worked in Maryland because it enables the state to support plans that have been developed at the local level.

In 1991, the Maryland General Assembly passed two laws that institutionalized flexible budget language. The flexible budget language allows each department's placement funds to be used to prevent placement, or to return children from placement. The legislation decategorizes millions of dollars already appropriated and allows more flexibility at the local level.

Data Collection

Data collection in the Children and Family Services Reform Initiative serves both accountability and self-monitoring functions for local programs. To account for progress toward achieving outcomes, quantitative and qualitative data are collected by local governing boards and entered, using the management information software package designed for the Initiative (see section, **Accountability**). Because the system is also self-monitoring, it can be queried at any time to determine where corrections need to be made. The system also provides information as to what aspects of the program are working well.

At first, state-level staff members of the Children and Family Services Reform Initiative found they had to encourage and support local staff in the use of the management information system for data entry and report production. With technical assistance and support from the state, and the expectation that reports be generated regularly from the system, local-level professionals are beginning to value the data collection process.

> *"Most people have gone into human services because they want to do something good. Now we actually have a system that supports them in doing that and also supports families. Workers are on call 24 hours a day, seven days a week. When a family is referred for services, the worker has an obligation to make contact with that family within 24 hours. I've done many interviews with families and they can't believe this is government—no waiting around and no red tape. You call someone and they answer the phone; you don't have to come in and fill out papers just to talk to someone. Families are overwhelmed by how responsive the workers are to them."*
>
> Donna Stark
> State Director
> Services Reform Initiative

Unique Features

A central feature of the Children and Family Services Reform Initiative is that decisionmaking is being moved from the state level to a level much closer to the families. The focus is on empowering families and communities. For example, a skill-building retreat was held for parents to help them develop the skills they need to become full partners in the process. Specific areas addressed at the conference included how to be assertive in meetings and how to identify the needs of their family. The intent of the reform is to go beyond the rhetoric and make an honest attempt at creating partnerships with families.

The Initiative uses a flexible funding strategy, which allows workers more flexibility in using funds that have already been appropriated.

Small caseloads are a priority. For example, caseload size for workers serving families with children at imminent risk of placement is 1 to 2. Therefore, the relationship between the worker and the family is significantly different than it was in the past.

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State Role

The first step in supporting the development of local governance structures such as those in Maryland's Children and Family Services Reform Initiative is to define local governance. The state should be able to articulate a clear definition of local governance and also provide training and support to local boards so that they can develop an appropriate structure.

A climate for change in which people are convinced that change needs to happen is important. It is important to have a vision for that change. It may not be clear as to how the vision will be operationalized across every dimension; however, having a vision is essential to initiating change at the local level.

State level personnel must be patient with the change process. Even with unanimous support, developing a new system and putting it into operation will take a considerable amount of time.

Finally, leadership at the top (e.g., the governor, the lieutenant governor) is important in supporting the development and maintenance of reform strategies. The support also of the General Assembly is needed to provide the opportunity to develop a plan, to test it, and to take risks with money and make resource investments. For example, the Maryland General Assembly demonstrated commitment by supporting budget language that allowed the use of all placement dollars to go toward the prevention of out-of-home and out-of-state placements. Therefore, $310 million were available to redirect toward the prevention of placement. The actions of the General Assembly reflected a restoration of faith in public agencies and confidence in the reform strategies.

New Mexico

COMMUNITIES IN SCHOOLS

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New Mexico

History

In 1989, the regional and national offices of Cities in Schools held meetings to introduce interested states to a new opportunity for a Cities in Schools grant. Subsequently, New Mexico submitted a proposal to the grant program. Because of New Mexico's scattered and predominantly rural population, the state chose to propose the implementation of Communities (rather than Cities) in Schools. In July 1991, a one-year $100,000 grant from the U.S. Department of Labor, the Department of Justice, and the national Cities in Schools office was awarded to fund three New Mexico sites. A state director was hired at 80% time. From July through December, the three-site selection process was publicized throughout the state, including presentations at events such as the *Governor's Summit* and the *Working Together Conference*. Thirty interested communities were visited by the state director.

In January of 1992, at the first meeting of a newly established State Advisory Board, the top four sites were presented. These sites had been selected on the basis of interest, readiness, types of collaborative initiatives already in place, and letters of commitment and support. Other community features considered were geography, ethnicity, and need. A community plan or project proposal was not required; communities needed only to provide letters of support and, after selection as a CIS site, to create a pre-implementation task force to conduct a needs assessment and establish a local CIS board. The initial plan of selecting three sites changed when the Board, the state director, and the community obtained assistance from US West in obtaining an additional $6,000 needed to fund a fourth site.

The four sites currently funded are Grant County (in the southwestern part of the state), the city of Las Vegas (northeastern New Mexico), Cibola County (in the central west), and Valencia County (outside Albuquerque). Cibola County serves tribal populations and includes tribal governance in its CIS project.

Mission & Goals

The State Advisory Board developed a mission for the overall initiative: "The mission of New Mexico Communities in Schools is to involve families, community, and government in developing and implementing innovative and collaborative services and programs to assist our youth to graduate from high school." The Board set forth the following eight objectives:

1. Improve school attendance and reduce the number of dropouts
2. Enhance personal, education, and social development
3. Improve youths' self-esteem and job skills
4. Encourage parental involvement in the education of their children
5. Reinforce socially acceptable behavior in the classroom, at home, and in the community
6. Coordinate timely and integrated delivery of human services to at-risk youth and their families within the education setting
7. Contribute to the chances of future employment or further education for at-risk youth
8. Develop successful employment attitudes and skills.

The primary goal of the CIS program is to reeducate the dropout population in communities by emphasizing the building of personal, educational, employment-related, and social skills of high-risk students. Funding from the Department of Labor led to a heavy emphasis on youth employability and preparation and training, as well as human service support for youth and families. New Mexico was able, through the Department of Labor, to obtain one seasonal worker position for its summer youth program and to reserve 120 positions in the summer youth program for CIS-identified high-risk youth. This arrangement enabled the four communities to provide a strong program for their CIS youth, including a variety of activities developed by the young people themselves and youth job placement beyond summer.

Though the mission, goal, and objectives of the CIS program have an emphasis on older children and youth, CIS communities view the mission of their implementations as encompassing younger children and the entire family. Also, the program has been placed under the state's new Children, Youth, and Families Department, which has a broader mission.

Collaboration

The Communities in Schools initiative is establishing partnerships among a wide range of entities that provide social and community services, including: maternal and child health staff in the Department of Health; child abuse prevention staff in the Department of Human Services; public and private schools; the probation, parole, and court system (including attorneys and court advocates); the Association for Retired Persons; foster grandparents; the Kiwanis, Rotarians, and other service organizations; the National Guard; the Armed Forces (preliminary work is being done with the Air Force); Drug Free Communities; the DARE drug abuse prevention program; and gang intervention and violence prevention entities.

Communities in Schools

Desired Outcomes

The major desired outcome of the Communities in Schools program is the development of a holistic approach to serving children, the entire family, and community in a comprehensive manner. The approach will depend on a strong working relationship between public entities, private organizations, and the community to, eventually, collaboratively fund CIS and ensure its continuation. The state will be looking for progress in the following areas:

- Increased parental involvement in the educational process
- Coordination of services among the school and external agencies that deliver services on campus
- The development of accountable, personalized, and interdisciplinary teams of service providers
- Co-location of staff from already-existing human service agencies and volunteer organizations
- Case management to ensure client-centered service delivery
- A relationship between the community and campus staff that coordinates tutors, mentors, and other volunteers.

Less directly, New Mexico's CIS is intended to be tangible evidence of the state's commitment to improving service delivery by eliminating duplication of services and making services coordinated and accessible. Visits by the state director serve to begin community dialogues regarding how residents need to work together and access services for their people.

State Functions

The State Advisory Board and the state director of Communities in Schools each plays a different role in facilitating the development and expansion of CIS programs in the state. The Board provides direction and supervision for the statewide program in the following ways:

- Provides statewide coordination to implement and expand CIS in New Mexico
- Provides a link with the national Cities in Schools organization to access resources for state and local programs
- Obtains state, federal, and corporate funding for operations and expansion of the CIS program in New Mexico
- Supports regional and local needs of individual communities in implementing CIS.

The State Advisory Board helps local boards and their communities identify critical local issues, face them as local problems, and devise local action plans. The Board provides direct assistance to CIS sites by helping with community assessments of leadership and of the community itself, providing training, and offering technical assistance when participating in on-site visits with the state director (e.g., helping facilitate site meetings). Regional staff also help with training in communities and with board training and fundraising.

The State Advisory Board engages in a high level of personal involvement with the four CIS communities. Community representatives are invited to make progress reports and interact with state-level members at State Advisory Board meetings. During these regular meetings, CIS staff provide information and attempt to facilitate dialogue between the community and Board members. Some Board members also work in the CIS communities, often participating on local boards. They use their influence at the local level to facilitate collaboration with local school boards and superintendents, and at the state level to provide access for the state director to the State Board of Education.

The Board also tries to be responsive to recommendations from the sites. Input from the four communities led to a commitment to postpone expanding the CIS program. The Board focused on the four current sites during the 1992-93 fiscal year—providing support, developing policies and procedures, and refining coordination—in an effort to identify and institutionalize necessary changes. The state director is providing limited technical assistance to communities in three other interested counties (Taos, Roosevelt, and Chavez) so that a smooth implementation can be assured when those communities join the CIS initiative in 1993-94.

The state director provides information and assistance to both the Board and individual CIS sites. She assists local CIS boards and communities by providing information on funding, resource development, Requests for Proposal (RFPs), conferences, training, and other opportunities that might be helpful to the communities. She also provides information related to CIS sites to the State Advisory Board and other state-level public and private entities. In this way, the director serves as a liaison between the CIS communities and the state, other public agencies, and private interests.

New Mexico

Membership & Organization

The State Advisory Board for Communities in Schools consists of cabinet-level secretaries from the Departments of Health; Human Services; Labor; Children, Youth, and Families (formerly the Youth Authority); and the Chief State School Officer. Ten other individuals were appointed by Governor Bruce King from various parts of the state, including one representative from each of the selected communities. As the CIS program expands, the State Advisory Board will expand to include representatives from each new site.

Each community has created a private, non-profit umbrella organization, or designated one that already exists (e.g., United Way), to house its local CIS board. These local entities go under various names, including Community Partnership; the Coalition for Children, Youth, and Families; and Community for Children, Youth, and Families. Status as a private, non-profit, incorporated institution makes the initiative community-owned and community-guided.

Each community also creates a pre-implementation task force of volunteers to accomplish a variety of start-up tasks, including: selecting or creating a 501(c)3 incorporated non-profit organization, conducting an assessment of leadership and community needs, fund-raising, and public relations. The task force also establishes a local CIS board by soliciting applications, nominating potential members, and selecting final members by vote. By rule, a maximum of 50% of board membership must be from public entities; the remainder is private. Members of the community board across all four sites include representatives from such entities as: the local departments of labor, human services, housing, public safety, law enforcement, education, health, and economic development; various governing entities (e.g., city, county, tribal); parents; community service providers; business; voluntary organizations; vocational and university institutions; and religious groups. Some of the CIS boards are considering involving a high-risk student on the board, or creating a student advisory council to provide input to the board.

Having non-profit status requires that the board establish bylaws that include guidelines for membership and officers. The board can recruit potential members periodically and fill vacant positions from the pool as they arise. Vacant positions are filled according to that member's affiliation as a public or private representative, but not necessarily with someone from his/her specific organization (i.e., a position held by a Health Department staff member must be filled by a public representative but not necessarily someone from the Health Department). All board members currently are full voting members. In an effort to expand the community's participation in the CIS program, however, one site is experimenting with the differentiation of board members' roles and voting status. Members of the executive, or working, board vote regularly on issues related to the CIS program. Membership on a general community board is open to anyone through payment of modest membership dues. The general board meets at least annually and all members have a vote.

Decisionmaking

Each local Communities in Schools board makes all decisions regarding selecting, hiring, and guiding the local community director. The board manages its finances, identifies local problems and training issues unique to the community, and is responsible for planning and implementing the CIS program.

For approximately one hour before a local CIS board meeting, there is a community input period so individuals from the community can raise issues and concerns, make announcements, share activities and celebrations, and make recommendations.

Accountability

The state is committed to working closely with local communities to enable the Communities in Schools boards and their programs to succeed. Each local board develops an annual working plan that identifies its objectives, defines responsibilities, sets timelines, and describes needed resources. The state director works collaboratively with the board during this planning process.

The state regards community outcomes as learnings that can inform changes at the state and local levels. If difficulties arise, the state considers them as a system issue and goes "back to the drawing table" with the community. Together they identify problems, determine what is not working, and decide what is needed to resolve them. Such collaboration might require a full discussion of the problem; if it's a financial issue, it may mean exploration of how to acquire needed resources.

CIS boards also participate in a broader research and evaluation effort under the auspices of the Children, Youth, and Families Department. That department is looking at the progress of numerous statewide collaborative initiatives.

Local Functions

Local Communities in Schools boards are engaged in a variety of functions related to their role as a liaison between community agencies and children, youth, and families. Major local functions include: (a) recruiting community agency personnel to deliver on-campus services, (b) coordinating campus services between external agencies and clients, (c) relocating services to other community sites, (d) making referrals to community organizations for services not available at the school site, (e) recruiting and coordinating volunteers, (f) providing parent support via home visits and help with basic needs (e.g., paying for utilities), and (g) reinforcing students' behavior and following up on problems outside of school through a community network of school and external agencies.

The boards also focus on empowering young people by getting them involved in meeting their own goals, and empowering the community by getting it involved in solving its own problems. For example, a "Take Back the Park" program by one CIS community brought people together to combat gang activity in a local park. Residents worked together to clean up graffiti and set up on-going activities for children and families.

Service Delivery

Case management and home visits are two important strategies used by Communities in Schools to ensure that service delivery is appropriate for families. A community focus leads some sites to sponsor or coordinate social, cultural, parent, and family events. Other sites organize recreational programs for youth, particularly in rural areas where the use of National Guard facilities and cultural outings are becoming major strategies.

A number of direct services are provided at CIS sites, including: (a) academic tutoring, (b) employment assistance, (c) job skills training, (d) legal and medical assistance, (e) gang prevention activities, (f) parent training, and (g) parent/child mediation. Counseling is provided at some sites, including substance abuse counseling via collaboration among community providers, the Health Department, and peer counselors.

Funding

The one-year grant from the U.S. Departments of Labor and Justice and the national Cities in Schools office ended June 30, 1992. Of the $100,000 budget, $24,000 was allocated at $6000 per Communities in Schools site. From July 1, 1992 through June 30, 1994, the state will have $50,000 for each program year from the Department of Labor, with 8 percent discretionary money. It is expected that carry-over money from the initial grant will supplement this amount.

State money is intended only to provide start-up assistance to a site. In 1992-93, the $6000 seed money was used by each local site to raise money to hire a community director. Some needed to raise 50% or less of the necessary money because a local agency was willing to pay for the position, or reposition someone part-time, or contribute funds to a pool to hire the director. All current CIS sites say they need directors who can devote themselves to coordinating and/or brokering resources and services and to monitoring the progress of proposals submitted on behalf of the CIS program.

At the local level, communities make in-kind donations of office materials, office space, and phones. CIS partners also engage in cost-sharing. In one community, for example, local representatives were able to attend a conference with the Department of Labor paying for meals, the school system paying for transportation, and CIS paying the registration fees. The business community also provides donations, fundraising, and resource development assistance.

At the state level, the state does a lot of fundraising and coordinating with other entities. For example, a percentage of DWI (drinking while intoxicated) court fines goes to substance abuse programs. The Department of Labor helped pay for travel and per diem for local CIS liaisons to travel to the State Advisory Board meeting. The state director helps communities identify resource opportunities (i.e., what Requests For Proposal are available) and provides technical assistance in writing proposals. She has given local boards a format for making requests for CIS projects. The state director also negotiated with the Juvenile Justice Advisory Committee and Department of Labor to get additional slots for CIS youth in the 1993 summer youth program, as well as another seasonal worker position for each CIS community.

Finally, the State Advisory Board wants to ensure that each new CIS community is provided $6000 seed money and a certain proportion of general state revenues will go to the sites that are already established. The State Advisory Board, state director, and Governor's Office are looking at the possibility of institutionalizing funding through legislation. There is also a commitment from the Children, Youth, and Families Department to help the CIS program succeed. This year's outcomes will provide the basis for recommending that each community get a funded director position.

Data Collection

Local Communities in Schools boards keep meeting minutes, make monthly reports, and develop case files of students. They also collect such data as: repositioned staff, repositioned hours, types of programs provided, referrals to the CIS program (including the number that are served within the program compared to outside the program), clients that need further services, volunteers, and hours provided by volunteers.

Optimally, the state wants data that demonstrate that the community has "stretched" itself, and the state has maximized its resources. The student case files are intended to show the number of students placed in jobs and the extent to which dropout, poverty, and crime rates have declined.

The state also is seeking a uniform approach to working with families. This requires an information system that will enable decisionmakers to gather data that will help them (a) identify system strengths and deficiencies, (b) facilitate collaboration in planning services, and (c) avoid duplication in service delivery. In this way, the state can show how system changes have eliminated resource expenditures in one area, enabling them to be used elsewhere.

> *"This whole process is very time-consuming; you have to be willing to put any agenda aside and take it where the community is. If you have things on the agenda and you're only on item three but it's really important to them, you need to be able to bring some closure to it before you move on or it will come back and bite you."*
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> Marty Mirabel
> Deputy Director for Community Planning
> Children, Youth, and Families Department

Unique Features

A unique feature of New Mexico's Communities in Schools initiative is the leadership that is committed to collaboration. Cabinet-level secretaries as well as the Governor and Mrs. King share and demonstrate a commitment to involving families, communities, and governments in collaborative efforts that help young people graduate from high school. The state is working to model collaboration and risk-taking for communities. State decisionmakers strive to communicate to local leaders that they must do business differently, and that they need community participation to do so. Various state initiatives, including the creation of the Children, Youth, and Families Department, are steps toward institutionalizing this commitment.

New Mexico is attempting to foster a blame-free attitude of accountability among all individuals and organizations. Realizing that conflict is likely to arise and differences need to be addressed rather than ignored, the state provides a mechanism and place for conflict resolution—it has set forth expectations for community involvement in local CIS board meetings and local participation at the State Advisory Board meetings.

Finally, to achieve local empowerment and collaboration, the state provides the most important resources: training, time, commitment, and appropriate technical assistance. State decisionmakers, for instance, are sensitive to the fact that communities who really need assistance often don't have and can't get the expertise to respond effectively to Requests for Proposal (RFPs). As a result, the state has worked to make it easier for communities to respond to funding opportunities.

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State Role

A state interested in supporting an initiative such as New Mexico's Communities in Schools needs to develop cross-system strategies involving all entities in the identification, definition, and resolution of problems. Another fundamental role for a state is tackling financing and resource issues. It also needs to develop a reliable information system that includes performance measurements and holds multiple agencies, rather than individual programs, accountable for achieving outcomes for families and children. In this last area, New Mexico is compiling a report card to assess the well-being of its communities according to such measures as poverty, graduation, and mortality.

The state needs to provide training on empowerment and collaboration to ensure that the top-down approach is eliminated, and that plans begin with communities and go forward. Between the state and local systems, there must be a systematic breakdown of isolation; state government must go out to communities. Mechanisms for conflict resolution must be identified, and a priority needs to be placed on understanding cultural differences. Within the state system itself, policies and job descriptions of staff at the client and supervision levels need to be seriously evaluated to see if they are written to enable individuals to do what they're being asked to do.

States must play a major role in communication, rather than depend on the media to educate the public about human needs. The public needs an awareness of both how children, youth, and families are faring, and how social services systems are performing.

Finally, state government needs to engage in cooperative decisionmaking with communities regarding funding priorities and, ultimately, funding requests to be made to the Legislature. The state also can take the lead in learning how to maximize federal entitlement funds and use or redirect existing dollars toward common goals.

Appendix

Conversation Guide

An Investigation of Local Governance Structures in Eight States, collaboratively sponsored by:

Texas Governor's Policy Council

Texas Health and Human Services Commission

Texas Department of Human Services

Southwest Educational Development Laboratory (SEDL)

Introduction

During this conversation we will be talking about the history, organization, and unique features of your state initiative and the local governance structures (LGSs) that implement the initiative at the local level.

State Initiative

1. Would you explain how the initiative started?

2. Can you describe the mission and goals of the initiative?

3. What specific outcomes does the initiative intend to achieve or help achieve in the state?

4. How does the initiative collaborate or coordinate with other federal or state initiatives and entities?

5. What does the state do to enable local governance structures to govern themselves and to carry out their functions as implementers of the initiative?

Local Governance Structures

1. Can you describe the membership and organization of the entity or entities that direct the local efforts?

2. What decisionmaking authority resides at the local level?

3. How are the LGSs held accountable for expected outcomes?

4. What are the major functions carried out by the LGSs?

5. If one function of the LGSs is to provide services to children, families, and other clients, what kinds of services do they deliver or contract?

6. Would you describe how the LGSs obtain and use funds to carry out their functions?

7. Do the LGSs collect data that are used, or will be used, by the state? If so, describe them.

Learnings

1. What makes this overall effort different from ways of doing business in the past?

2. How would you suggest that states support the development and maintenance of local governance structures designed to improve the delivery of health and human services at the local level?

Interviewees

Arkansas
Arkansas Families First

Ann Kamps, Special Assistant
Family Policy Council
Office of the Governor

Kenny Whitlock, Director
Economic and Medical Services
Department of Human Services

California
Healthy Start (Senate Bill 620)

Jane Henderson, Assistant Superintendent
of Public Instruction
California Department of Education

Colorado
Family and Children's Initiative

Claudia Zundel, Family Center Coordinator
Office of the Governor

Florida
District Health and Human Services Boards

Bill Bentley, Assistant Deputy Secretary
for Human Services
Department of Health and Rehabilitative Services

Kayce Morton, Governmental Analyst
for Planning and Budgeting
Office of the Governor

Paul Belcher, Policy Coordinator
for Health and Human Services
Office of the Governor

Lucy Hadi, Deputy Secretary for Management Systems
Department of Health and Rehabilitative Services

Iowa
Family Development and Self-Sufficiency Program

Bette Crumrine, Program Manager
Family Development and Self-Sufficiency Program
Department of Human Rights

Rodney K. Huenemann, Chief
Bureau of Community Services
Division of Community Action Agencies
Department of Human Rights

Kentucky
Family Resource Centers and Youth Services Centers

Tom Willis, Legislative Fiscal Analyst
Legislative Research Commission

Maryland
Children and Family Services Reform Initiative

Donna Stark, State Director
Services Reform Initiative

New Mexico
Communities in Schools

Marty Mirabel, Deputy Director for Community Planning
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